Exploring the Relationship between Emotion-Focused Coping and Posttraumatic Stress among Women Who Have Experienced Intimate Partner Violence

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Dedication

This thesis is dedicated to mother and father, Shirin and Kamran Samimi. They are with me always. I also dedicate this thesis to my husband, Paul Hanley and to my son, Kamran Samimi, who are the reasons I strive to make this world a better place.

Abstract

Women who have experienced violence in their intimate partnerships have consistently reported poorer physical and mental health and higher medical care utilization than women who have not experienced intimate partner violence. Because of the many deleterious impacts of relationship abuse, investigations into coping processes among women who have experienced intimate partner violence take on heightened importance. The complexity of circumstances and the unique responses to intimate partner violence indicate that women employ as many coping strategies as are available to them at the time. Effective coping behaviours and the recovery environment are critical for battered women's positive adjustment (Carlson, 1997; Sullivan & Bybee, 1999). This study examined the relationships between emotion-focused coping, symptoms of post-traumatic stress and exposure to intimate partner violence in a sample of 670 women across the Prairie Provinces. The Composite Abuse Scale, Emotion-Focused Coping Strategies questionnaire, and the Posttraumatic Stress Checklist were used to measure the variables. Findings confirmed a strong correlation between greater exposure to abuse and symptoms of posttraumatic stress. They also confirmed that greater use of emotion-focused coping strategies was associated with escalation of abuse and more symptoms of posttraumatic stress within this group of women. This study adds to the current body of literature on ways women cope with intimate partner violence.

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CHAPTER 1. INTRODUCTION

1.1 Introduction

The epidemic of intimate partner violence (IPV) has been brought to the attention of policy makers, judicial systems, and healthcare providers due to its effects on the lives of women and children. This is not a new phenomenon, but it has become a significant area of concern for many communities in Canada and the world. Intimate partner violence is a pervasive social problem that compromises the personal health and safety of millions of women each year (Bachman & Saltzman, 1995; National Coalition Against Domestic Violence, 1995; Plichta, 1996). The Canadian Women's Foundation (2011) based in Ottawa reports that on average, every six days a woman in Canada is killed by her intimate partner. On any given day in Canada, more than 3,000 women (along with 2,500 children) are living in emergency shelters to escape domestic violence. Furthermore, half of all women in Canada have experienced at least one incident of physical or sexual violence since the age of 16 and over half of all Canadians say they personally know at least one woman who has been sexually or physically assaulted. Statistics Canada (2006) findings indicate that women were more likely to report that they were targets of more than ten violent incidents at the hands of their partner and more likely to state that they were injured as a result of the violence than were men (44% versus 18%) in 2004. Female victims were also three times more likely than male victims of spousal violence to fear for their lives and three times more likely to take time off from their everyday activities because of the violence. The cost of violence against women in Canada, for health care, criminal justice, social services, and lost wages and productivity, has been calculated to be $4.2 billion per year, according to Canadian Women's Foundation (2010).

The deleterious effects of intimate partner violence on women's mental health are far reaching and place women at higher risk of experiencing more violence in intimate relationships. The need for immediate mental health intervention has increased due to such outcomes as depression, anxiety, and impaired self-esteem, a few of the mental health consequences experienced by women who have experienced IPV. Posttraumatic Stress Disorder (PTSD) and symptoms of PTSD have commonly been found in women who have been exposed to a traumatic event such as IPV (American Psychiatric Association, 2000). There is also a greater need for faster and more effective law enforcement interventions as a result of rape, stalking, and murders perpetrated by intimate partners.

Literature draws attention to the effects IPV has on children exposed to IPV. Research suggests that children are also subject to the violence and experience high levels of emotional stress. They in turn become either victims of IPV or perpetrators of IPV in adult life. The outcomes of IPV must be addressed to reduce and ultimately eliminate violence towards women. Research is one way to improve our understanding of how women who experience IPV might increase their protective factors.

Establishing effective coping and recovery environments for women who have experienced IPV is considered critical for their psychosocial adjustment and overall well-being. Nonetheless, there is a notable dearth of investigations examining the relationship between different forms of coping and mental health outcomes among this population (Taft, Resick, Panuzio, Vogt, & Mechanic, 2007b). Given the complexity and unique life experiences and circumstances of each woman, there are numerous ways in which coping strategies are expressed. Indeed, Smith, Murray, and Coker (2010) suggested that a battered woman's coping strategies must be understood, first and foremost, in relation to the context of survival. For

example, she may prefer to use more "active" approach strategies to solve problems in the work domain, while choosing strategies that avoid solving problems directly with a severely violent husband. As such, it is expected that outcomes of research on coping and posttraumatic stress symptoms will vary accordingly and may at times appear inconsistent.

The majority of research on coping strategies has basically been divided into two streams or approaches, namely problem-focused and emotion-focused strategies. Taft, Resick, Panuzio, Vogt, and Mechanic (2007a) suggested that problem-focused coping refers to taking active steps towards altering the source of stress. For example, a woman using problem-focused coping might make a plan of action and follow through with it. Emotion-focused coping involves attempts to manage the emotional distress accompanying a stressor. For example, a woman might keep her feelings to herself or refuse to believe that the violence even occurred. She may have to resort to this strategy because curbing the severity of the experience of violence is the best she can do if she lacks the necessary support resources that would or could protect her.

The use of problem-focused coping strategies may seem preferable given that it is considered a more "active" response to the violence and it may also be associated with lower rates of posttraumatic stress symptoms. Problem-focused coping provides women with a sense of control over the violence by taking active steps; for example, they might confront the abusive partner, leave the relationship, or seek legal action. However, given the tenuous position of many women in abusive relationships (often undereducated and/or unemployed or impoverished), they may not have the resources to leave the abusive relationship (Lilly & Graham-Bermann, 2010). With these constraints, many women may use emotion-focused coping strategies as a means of alleviating mental distress. For example, they may need to resort to positive reappraisal of their circumstances, pray, or deny or minimize the severity of the abuse as a ways of reducing the

negative affect or psychologically reconstituting their mental and emotional framework. Thus, emotion-focused coping may be considered as highly valuable given its ability to deal with the challenges of IPV when she attempts to engage in problem-focused coping. Lilly and Graham-Bermann (2010) further state that there is ample evidence that under certain conditions—particularly those in which nothing can be done to change the situation—rational problem-solving efforts can be counterproductive and may even result in chronic distress when they fail. In such circumstances, emotion-focused efforts may offer the best coping choice. Literature on coping suggests that there are no preferable coping strategies for all women. Rather, the use of a particular form of coping may be related to a woman's perception of control in her situation at any given time. Research also suggests that posttraumatic stress symptoms have been found among women who have used both problem- and emotion-focused strategies. This finding points to the possibility that the relationship between IPV, coping, and posttraumatic stress is not as straightforward as one would expect. Nonetheless, the need to further explore the areas of coping, especially with respect to women who have experienced IPV, demands further attention.

Some women manage to survive and emerge from abusive relationships with fewer negative outcomes than others. Despite the tremendous amount of research on coping over the past two decades, studies of coping strategies in samples of battered women are few (Waldrop & Resick, 2004). There is a need for research that investigates coping strategies utilized by battered women that preserve their psychological functioning and their physical well-being during and after battering relationships. It is critical to examine factors that may contribute to potentially effective and ineffective forms of coping since coping may vary greatly across women's experiences and may change in response to different patterns of violence. Even though no published study has been found to examine all the correlates of coping variables

comprehensively, some research within the general coping and IPV literature suggests the potential importance of incorporating explorations of abuse-related factors, socioeconomic factors, social coping resources and family of origin history of trauma. Taft et al. (2007a) suggested that investigations that shed light on optimal coping strategies for battered women are urgently needed to inform intervention, prevention, and advocacy efforts.

There is a disturbing scarcity of research on coping strategies, particularly emotion-focused coping strategies used by women experiencing IPV. An extensive literature search found that there was no research done on emotion-focused coping strategies and posttraumatic symptoms within the context of intimate partner violence. To date, this study is the first examination of the relationship between emotion-focused coping strategies and symptoms of posttraumatic stress among women who have experienced IPV. This study may add to the current literature on the relationship between emotion-focused coping and posttraumatic stress for women experiencing intimate partner violence.

1.2 Purpose of the Study

Due to limited research on coping strategies used by women who have experienced intimate partner violence and posttraumatic stress, the purpose of this present study was to add to the current body of research on coping. Although coping and recovery from IPV are thought to be critical for the psychosocial adjustment of women who have experienced IPV, there has been a notable dearth of empirical investigations examining the relationship between different forms of coping and mental health outcomes among this population (Taft et al., 2007a).

Coping behavior inherently implies "conscious thoughts and behaviors used to manage internal or external stressors that exceed one's existing resources" (Krause, Kaltman, Goodman, & Dutton, 2008). Recent research on two forms of coping, namely problem-focused and

emotion-focused coping, have advanced our understanding of women's experiences in abusive intimate partnerships by confirming the complex and oftentimes diverse ways in which women have to cope. It is hoped that an advancement of understanding may enhance the knowledge base of effective coping behaviors and recovery environments that are critical for the women's positive adjustment (Taft et al., 2007a). Nonetheless, IPV remains a current and relevant issue in our world. While most research efforts have concentrated on problem-focused coping strategies, the implications of externalizing solutions to coping and internalizing aspects of coping, namely emotion-focused coping, have been largely ignored. Interestingly enough, Smith et al. (2010) suggested that disengagement, or emotion-focused coping, is experienced uniquely by women who are battered.

The purpose of this study was to: 1) explore the relationship between the experience of violence and posttraumatic stress, and 2) explore the relationship between posttraumatic stress and use of emotion-focused coping with a sample of 670 women who have been exposed to IPV. This study may contribute to a body of knowledge that may reduce IPV and the consequences of IPV from women's lives.

1.3 Research Question and Hypotheses

The current research sought to explore the following key questions:

Is there a relationship between IPV and symptoms of posttraumatic stress as measured by the Composite Abuse Scale and the Posttraumatic Stress Checklist among women who have experienced IPV? Is there a relationship between exposure to IPV and the use of emotion-focused coping strategies as measured by the Emotion-Focused Coping Strategy index among women who have been exposed to IPV? Is there a relationship between the use of emotion-

focused coping strategies and symptoms of posttraumatic stress among women who have experienced IPV?

The research was conducted using the null hypothesis significance testing stating that:

(1) There is no relationship between exposure to violence as measured by the Composite Abuse Scale (CAS) and reported symptoms of posttraumatic stress as measured by the Posttraumatic Stress Checklist (PCL) among women who have experienced IPV.

(2) There is no relationship between exposure to violence as measured in the CAS and use of emotion-focused coping strategies as measured in the Emotion-Focused Coping Strategies index (EFCS).

(3) There is no relationship between use of emotion-focused coping strategies as measured in the EFCS and symptoms of posttraumatic stress as measured in the PCL.

CHAPTER 2: LITERATURE REVIEW

This chapter examines research on women's experience of IPV. Definitions and features of IPV are followed by a review of the literature on coping, particularly in the context of IPV, and posttraumatic stress as an important health concern for women exposed to IPV.

2.1 Defining Intimate Partner Violence

Research literature varies widely in defining the phenomenon of violence against women. Some definitions include psychological, emotional, and verbal abuse; neglect; economic or financial abuse; and sexual coercion and assault. A variety of terms have been used to refer to intimate violence in the literature, including wife battering, domestic violence, domestic abuse, marital violence, wife assault, woman abuse, and partner abuse (Crowell & Burgess, 1996). The term Intimate Partner Violence (IPV) remains the dominant terminology for this thesis because it is descriptive of the relational context in which the woman experiences the abuse.

Sanderson (2008) defines IPV as any incident or pattern of controlling or threatening behavior, violence, or abuse (psychological, physical, sexual, financial, emotional, or spiritual) between adults who are have been intimate partners regardless of gender, sexuality, disability, race, or religion. This study focuses on women who have experienced IPV. Sanderson (2008) suggested that this abusive behavior towards women, which escalates with the passage of time, is used as an effort to control the woman based on the perpetrator's sense of entitlement and dominance as the survivor's level of submission increases.

Ultimately, IPV has serious and lasting effects on a woman's sense of self, mental and physical well-being, and autonomy. Oftentimes, physical abuse is used as coercive control to inculcate fear thus promoting domination by the abuser. This behavior ensures submission of the victim, mainly the intimate partner, but may also be directed at others, especially children, with the intention of hurting the intimate partner (World Health Organization, 2006).

The severity of the coercive influence of IPV can be understood as a continuum (Renzetti Edelson, & Bergen, 2001; Sanderson, 2008; Walker, 1980). Arriaga and Oskamp (1999) defined the continuum of IPV as a sophisticated process whereby various correlates and mechanisms of violence that precede and follow the acts of violence vary in range and types of violence used. One example of a process whereby a pattern of violence occurs may begin when the partner engages in name calling, put downs, and insults, then proceeds to prevent a woman from going to work or school. From there he may prevent his partner from associating with family members or friends, then he tries to control how she spends money, where she goes, and what she wears. Acts of jealousy, possessive behaviours, and accusations of infidelity could follow. If alcohol or drug use is involved, the violence can escalate from threats of physical violence to actual physical violence with a weapon. Hitting, kicking, shoving, choking, hurting the children or pets might take place. Forced sex or engaging in sexual acts against a woman's wishes may take place, and sometimes blaming the woman for the perpetrator's violent behaviour follows this. Sometimes the sexual violence is portrayed as mutual and consensual. Research confirms that the pattern of violence may vary from couple to couple, but there are behaviours that are commonly recognized as familiar among perpetrators of violence towards women in an intimate partner environment.

In a longitudinal study on patterns and characteristics of IPV among 436 homeless and extremely poor mothers receiving social assistance in Massachusetts, Bassuk, Dawson, and Huntington (2006) described the continuum of abusive behavior through "risk markers" or defining characteristics that could place women at further risk. These characteristics could be childhood trauma, extreme poverty, addictions, and neglect, to name a few. They discovered that almost two thirds of the women experienced IPV at some point in their adult lives with continued

recurrence thereafter. Their study found that very poor women with a childhood history of physical or sexual abuse faced four times greater risk of victimization by a partner in adulthood. Adult risk-markers included inadequate emotional support from non-professionals, poor self-esteem, and a partner with substance abuse problems and poor work history (Bassuk et al., 2006). Additionally, numerous studies have shown that past partner violence can be predictive of current partner violence.

Demographic characteristics of women who have experienced psychological abuse, for example, may differ from those experiencing physical or sexual abuse. Further, women who have experienced physical and sexual violence may experience more severe violence than women experiencing physical violence alone (Coker, Smith, McKeown, & King, 2000). The various correlates and mechanisms of violence can be complex and, at times, difficult to reduce to a singular theoretical explanation.

2.1.1 Range and Types of Intimate Partner Violence

Release of information on prosecution of IPV from the British Crown Prosecution Service (2011) identified that the range and types of IPV include physical, verbal, and non-verbal (psychological, mental, and emotional) abuse, sexual assault, stalking or cyber stalking, economic or financial abuse, various forms of spiritual abuse, and even homicide. The boundaries between these various forms of abuse can often be blurred and it is unusual for one type of abuse to occur in isolation. For instance, physical abuse is often used to instill fear that facilitates the use of power control and domination to ensure submission of the survivor.

In their critical review of current research on psychological abuse in context of women's experiences of IPV, O'Leary (2001) identified passive and active manifestations of IPV. They claimed that passive IPV is covert or suppressed anger, which is often displayed as a lack of

concern for the victim, poor care, emotional neglect, or failure to protect. Active IPV is manifested as overt anger directed at the victim, resulting in assault, injury, intimidation, rape, or murder. The different types of abuse by perpetrators will vary from individual to individual, and are oftentimes inextricably intertwined and very difficult to disentangle.

The types of IPV are as follows:

Physical abuse can be either controlled or impulsive, and it commonly consists of physical assault (Sanderson, 2008), which includes slapping, punching, kicking, biting, shoving, choking, or using a weapon to threaten or injure (Martz & Saraurer, 2002). These actions result in injuries ranging from bruising, scalding, burning, or stabbing, to internal injuries, broken bones, or head injuries. Other forms of physical abuse can leave no visible evidence such as the forcing of an ice-cold bath, asphyxiation, or incarceration by locking the individual up, and physical neglect, including deprivation of food, sleep, elimination, shelter, health care, or appropriate clothing. Ultimately, these behaviours can result in death of the victim (Sanderson, 2008).

Sexual abuse, as defined by Abraham (1999), includes sex without consent, sexual assault, rape, sexual control of reproductive rights, and all forms of sexual manipulation carried out by the perpetrator with the intention or perceived intention to cause emotional, sexual, and physical degradation to another person.

Financial or economic abuse is characterized by the abuser denying the partner access to cash or credit, and exercising control over all financial decisions, including major purchases and or holidays (Sanderson, 2008). This form of abuse also sabotages the woman's efforts to become self-sufficient through education, job training, employment, and/or sustaining employment (Renzetti et al., 2001).

Spiritual abuse implies the imposition of beliefs on others with the intention of controlling them. Spiritual abuse can lead to social isolation and impede the survivor from seeking assistance or protection through links in the community (Martz & Saraurer, 2002). This type of abuse can also manifest itself as the perpetrator demanding the woman to "serve" her husband to act in accordance with the will of God.

Neglect occurs when women are ill or recovering from illness, or when they are pregnant or have recently delivered a baby. It is manifested as not providing for the general needs of the woman (and children), such as deprivation of means to purchase food and clothing when needed.

Psychological abuse consists of denigration to the woman's self-image or -esteem, passive-aggressive withholding of emotional support and nurturance, explicit or implicit threatening behavior, and restriction of personal territory and freedom (O'Leary, 2001).

Verbal abuse is a form of psychological abuse. Verbal abuse often includes constant criticism and name-calling. It also includes unjust blaming, false accusations about fidelity or sexual actions, and repeated threats of violence against another person, such as the victim's friends, relatives, and/or pets (Martz & Saraurer, 2001).

Stalking is a course of conduct directed at a specific person that involves repeated visual or physical proximity, non-consensual communication, or verbal, written, or implied threats, or a combination thereof, that would cause fear in a reasonable person (Renzetti, Edleson, & Bergen, 2001).

Intimate Femicide is homicide directed towards women by a current or former partner (2006; Gartner, Dawson, & Crawford, 2002; Renzetti et al., 2001).

2.1.2 Personality Features of Intimate Partner Abusers and Dynamics of IPV

In addition to the identification of the various types and ranges of violence present in relationships, Dutton (1999) included a review on the various trauma models and intergenerational transmission of violence towards women. Dutton suggested that the personality of male abusers contributes to some identifiable dynamics present in IPV, as does the history of violence in the abuser's family. Dutton incorporated a social learning theory to include family of origin experiences where there is a presence of various forms of abuse, as this history may comprise the main elements that shape abusive personalities. In this instance, Dutton stated that men who exhibit features of the abusive personality tend to demonstrate cyclical abuse corresponding to the phasic nature of their personalities. "Phasic nature" of intimate partner violence, as defined by Lenore Walker (1980), is a phenomenon in battering called the "cycle of violence". She stated that these cycles emerge as patterns of behavior in relationships wherein abuse towards the woman is perpetrated. Predictably, the cycle goes through three phases, with each phase lasting a different length of time. Walker further stated that the duration of each phase would vary among individuals, with the total cycle lasting anywhere from a few hours to months or even years. In many cases, the cycle of violence speeds up over time, with violence erupting much earlier on in the perpetrator's continuum of abusive behavior. Some of the phases can be quite subtle but pivotal in traumatic bonding, thus making it difficult for survivors to identify the cyclical nature of IPV and making it harder for them to seek help. Male partners who abuse their intimate female partners commonly intersperse verbal and emotional abuse with bouts of physical violence.

The first phase is called the *tension-building stage,* in which both the batterer and the battered woman experience an escalation of tension and a gradual incubation period for

increased internal pressures. The tension between the two people becomes untenable and graduates to the second phase, called the *abuse* or *crisis phase.* This phase is characterized by the uncontrollable discharge of tensions that had built up during phase one. The lack of control and the eruption of physical and verbal assaults are portrayed as the phase of major destruction. Women are at highest risk of being hurt during this phase. Once the rage has been vented, it is replaced with contrition and remorse. It is the third stage, the *reconciliation* or *honeymoon phase*, which is critical in keeping the batterer and the survivor in the relationship. Extremely loving, kind, and contrite behavior characterize this phase by the abuser. The abuser begs forgiveness and usually vows that he will never abuse again. He also believes he has taught his partner a lesson so she will no longer behave in a manner that would tempt him to abuse her again. Often, abusers lavish their partner with attention, gifts, and special treats during this phase (Sanderson, 2008; Walker, 1980).

2.1.3 Prevalence of IPV

Although both men and women report IPV victimization, it is more prevalent among women than men, and differences between women's and men's rates of victimization increase as the severity of physical assault increases (Stets & Straus, 1990). Female victims of IPV are significantly more likely than men to sustain an injury, receive medical care, be hospitalized, receive counselling, and lose time from work (Tjaden & Thoennes, 2000). Relative to men, women are more likely to be injured if they are victimized by an intimate partner than if they are assaulted by someone who is not considered intimate (Bachman & Saltzman, 1995). Women are 13 times more likely to suffer an injury at the hands of an intimate partner than from an accident (Stark, Flitcraft, & Frazier, 1979).

Literature does not provide consistent statistics on the prevalence of IPV, nationally or internationally, which may in part be due to the varying instruments used for measuring IPV and inconsistent parameters for defining IPV. Nonetheless, there is compelling evidence that violence against women is severe and pervasive throughout the world. Surveys on violence against women conducted in at least 71 countries show that a significant proportion of women suffer physical, sexual, or psychological violence (UN Secretary-General, 2006).

In a study based on interviews of 24,000 women from rural and urban areas in 10 countries, the World Health Organization (2005) revealed that IPV is the most common form of violence in the lives of women. On average, at least one in three women is subjected to intimate partner violence in the course of their lifetime. The study showed that the percentage of women subjected to sexual violence ranged between 6 to 59 percent. The proportion of psychological violence ranged from 10 to 51 percent worldwide. The first French national survey on violence against women found that 35 percent of women had experienced psychological violence by an intimate partner over a 12-month period. Furthermore, the study found that one quarter to one half of all women who had been physically assaulted by their partners said that they had suffered physical injuries as a direct result. Even if the violence had occurred years earlier, these women were also twice as likely as non-abused women to have poor health and physical and mental problems, including suicidal thoughts and attempts, mental distress, and physical symptoms like pain, dizziness, and vaginal discharge.

In its most recent report, Statistics Canada (2006) stated that the overall five-year rate of spousal violence (inclusive of common-law partners) has remained unchanged at 7% since 1999. This means that an estimated 653,000 women and 546,000 men encountered some form of violence by a current or previous spouse or common-law partner. The data also showed that

about 30% of women surveyed said that the violence either continued or occurred after separation. The nature and consequences of IPV were more severe for women than for men. About 44% of the women indicated that they suffered injuries resulting directly from the violence. The General Social Survey from Statistics Canada (1999) also reported that the most serious form of violence experienced by women was being beaten, choked, or threatened with a gun or knife. They were more than twice as likely as men to be injured and to be targets of more than 10 violent episodes, and they were three times more likely to fear for their lives. Women were five times more likely than men to fear for their lives (Statistics Canada, 1999). These results are consistent with data that indicate that women suffer from more severe acts of spousal assaults than men and are more likely to be killed by a spouse during periods of marital separation. In their 2006 report titled, "Measuring Violence against Women," Statistics Canada reported that Aboriginal women and women residing in the territories (i.e., Yukon, Northwest Territories, and Nunavut) experienced over three times more violence than the general, non-Aboriginal population of Canada.

2.1.4 Costs and consequences of IPV in Canada

The United Nations Secretary General Report (2006) stated that the impact of economic costs of violence against women in Canada is difficult to gauge. Yet, it appears that both the direct and indirect costs are extremely high. These costs include the direct costs of services to treat and support survivors of IPV and their children, and to bring perpetrators to justice. The indirect costs include loss of employment opportunities and productivity, and the costs related to human pain and suffering. In Kerr and McLean's (1996) research paper conducted for the Ministry of Women's Equality, results showed that, in British Columbia alone, the partial economic costs of violence against women were estimated at $385 million. Furthermore, if the

missing costs of health care, child services, housing, legal services, and intergenerational effects were added to the $385 million, the quantifiable costs of violence against women for British Columbia alone would likely approach $1 billion per year. However, Day's (1995) study about the nature of violence in women's lives in Canada showed that the total annual measurable costs of IPV relating to health and well being alone amount to over $1.5 billion. Another research paper using survey samples of Canadian women, government statistics, case studies and other reports estimated preliminary partial social services/education, criminal justice, labour/employment, and health/medical costs of violence against women to be at $4.2 billion. The results showed the profound effect violence has not only on the lives of Canadian women, but also on governments, institutions, and businesses. And yet, because the data in all policy areas are incomplete, and in some cases non-existent, the authors claim that the report captures only partial estimates of the economic costs of violence against women (Greaves, Hankivsky, & Kingston-Rieches, 1995). If one then considers the pain and suffering, the loss of life, the lost potential, and the damage to the lives of the assaulted women and their families, especially the children, the total costs of violence against women are truly staggering.

2.1.5 Theories of IPV

There is no single theory capable of explaining the complexity of IPV. Crowell and Burgess (1996) suggested that research has sought causal factors at various levels of analysis, including individual, dyadic, institutional, and social. They also suggested that studies of offending and victimization remain conceptually distinct from each other except in sociocultural analysis in which joint consideration is often given to two complementary processes: those that influence men to be aggressive and channel their expressions of violence towards women, and those that position women for receipt of violence.

Although there is no single theoretical model for IPV, the most commonly used theory in the research literature is social learning theory. Sev'er (2002) suggested that social learning and, by extension, general culture of violence theories (i.e., sociocultural theories), assert that violence is learned through observation, modeling reward systems, or lack of punishment, and thus highlight the inter- or intra-generational transmission of violence. Holt and Gillespie (2008) contended that intergenerational transmission of violence suggests that violence can be passed from one generation to the next. Routt and Anderson (2011) conducted a study of adolescent violence towards parents in King County, Washington. Their research attributed causal status of transmission of violence to variables that may have occurred or arisen after the violent or abusive act from the parents, guardians, or caregivers. This is to suggest for example, that when a parent models violence a child learns that aggressive behavior is a way of getting what he or she wants. When the child's use of violence and aggression succeeds, the reward is a powerful incentive to repeat the same behavior.

White, Donat, and Bondurant (2001) examined common factors contributing to various forms of violence by using a developmental perspective to understand the "roots of violence against women." Their review exposed the patterns of play among girls and boys, parental punishment, and childhood abuse as indicators of using abusive behaviour in future relationships. Boys receive numerous messages that distance them from girls; the use of aggression to express interpersonal power and control is tolerated by family members and their social environment. Girls, on the other hand, receive messages that encourage submission and that discourage them from defending themselves against aggression. Additionally, some girls and boys learn that girls' bodies are not their own, and that caretakers have dominance over their bodies. These experiences set the stage for patterns of behavior that emerge during adolescence when intimate

heterosexual interactions develop. By observing male–female interactions at home, among peers, and in the media, children learn that boys should be dominant and girls submissive, and that boys are agentic and girls passive.

The director of the Women's Mental Health Program at the University Health Network and professor of psychiatry and obstetrics/gynecology at the University of Toronto, Dr. Gail E. Robinson (2003) authored an article on concepts and etiology in intimate partner violence. She stated that boys who grow up in violent households learn a pattern of solving disputes through the use of violence. Men who grow up in abusive households are three times more likely to be violent towards their own wives and to inflict more serious and repeated assaults. Girls in such households grow up to be more passive, are at increased risk of becoming victims themselves, and may come to believe that violence is an appropriate way to resolve conflict. Robinson (2003) further suggested that as adults, these men tend to have low conflict resolution skills and show traits of insecurity, dependency, possessiveness, low self-esteem, and low stress tolerance.

White et al. (2001) concluded that violence towards women occurs across the life cycle; childhood victimization increases the risk of further victimization during adolescence, and adolescent victimization increases the risk of revictimization during adulthood, thus suggesting that there are serious long-term psychological and physical consequences of victimization across the lifespan.

2.1.6 Dispelling Myths and Assumptions about IPV

There are a number of prevailing myths about the women who experience IPV and the men who perpetrate the violence. It is not within the scope of this review to explore, discuss, and dispel all of the myths current in our literature, but it is relevant to highlight the two most commonly recognized myths about IPV. Renzetti et al. (2001) suggested that two central lines of

inquiry that have led to several commonly held myths about women in violent relationships relate to how women become involved with violent partners and why they stay in these relationships. The authors state that the myths stem from traditional values or attempts to understand the unbelievable, i.e., why a sane woman could actually be "stuck" in a bad relationship. People often try to make sense of these bad situations and end up maintaining harmful stereotypes that perpetuate IPV. Both women and men who are influenced by traditional worldviews on the roles of women and men hold many of the myths and assumptions about IPV.

Lundberg-Love and Marmion (Eds.) (2006) identified some of the existing myths that keep the victims stuck in their situations and decrease their opportunities to get the help they need. Some of the myths identified are the following: if a woman is abused, she can easily leave the situation; many women invite violent behavior or abuse; IPV is usually a one-time, isolated occurrence; and persons who commit such violence are psychologically deranged or psychotic. Other myths include that victims should get over it because there are no long-lasting effects and a strong woman is stronger when she puts the violence in the past; sexual abuse is not about sex, and if a woman were providing her partner with adequate sex, he would not be abusive to her; women are just as violent as men; IPV only happens in poor families; violence against women is worse in other countries; and if the woman is understanding and patient, things will get better. The authors suggested that these myths are not only harmful to victims of IPV, but they also perpetuate IPV because they are inherently dismissive and diminishing of women's lived experiences with IPV.

Sanderson (2008) recommended the need to examine current myths of IPV and evaluate them in relation to recent research and to identify our own biases and stereotypes surrounding IPV. In their review of research on perceptions surrounding IPV, Harrison and Esqueda (1999)

found that the reasons women become involved with partners who are violent or stay in their relationships are far more complex than blanket statements made about the woman's character, family of origin history, or strength of will. According to Harrison and Esqueda (1999), women remain in abusive relationships for three reasons: they lack resources, they face limited or ineffective responses by services and authorities, and they are beholden to traditional thinking.

2.2 Coping

Intimate partner violence is a severe stressor that affects women's mental health and quality of life. Research indicates that the way women cope with the adversity of IPV impacts their psychological adjustment. This section explores the literature on coping and its relationship to IPV.

The large body of literature on coping is based on an examination of individuals' responses to stressors and everyday disturbances commonly found in populations that have experienced war-related activities, poverty, and grief or loss, to name a few. Because of the many deleterious impacts of woman abuse, investigations into coping among women who have experienced IPV take on heightened importance (Taft et al., 2007b). There has been a notable dearth of empirical investigations examining the relationship between different forms of coping and mental health outcomes among this population. Investigations on how women cope with IPV are urgently needed to inform intervention, prevention, and advocacy efforts (Taft et al., 2007a).

Intimate partner violence presents a particular set of circumstances within which certain forms of coping takes place. In their paper examining the current literature on coping among women who have experienced IPV, Waldorp and Resick (2004) suggested that IPV is a source of a great psychological distress for many women. Yet, some women manage to survive and emerge from abusive relationships with fewer negative outcomes than others. This further

suggests the need to investigate battered women's coping strategies that preserve their psychological functioning and their physical well-being during and after violent relationships.

2.2.1 Definition of Coping

Although there are various definitions and classification systems proposed for coping, Snyder and Dinoff (1999) introduced one definition that encompasses many previous views of coping; it is a response aimed at diminishing the physical, emotional, and psychological burden that is linked to stressful life events and daily hassles. According to this definition, coping strategies are those responses that are effective in reducing an undesirable "load" (i.e., the psychological burden). Folkman, Lazarus, Dunkel-Schetter, DeLongis, and Guren (1986) examined the effects of coping on physical and psychological outcomes. They defined coping as cognitive and behavioural responses used to manage internal or external demands perceived as taxing or exceeding the person's resources.

Folkman and Lazarus (1985) conducted a study with college students (N=261) about to take a midterm exam. They assessed the students at three stages of the examination: the anticipation stage before the exam, the waiting stage after the exam and before grades was announced, and after grades was posted. Their study described their use of their process theory, also known as the transactional model of coping. To date, process theory has arguably been the most influential theory of coping introduced in the field. Lazarus (1993) stated that this coping theory derived its name from a process perspective, which viewed coping for each individual as changing over time and in accordance with the situational context in which coping occurs.

Lazarus and Folkman (1984) stated that coping strategies have two important functions. The first or primary function that a coping strategy serves is to manage the problem that is causing stress. The other function dictates that the emotions relating to the stressor need to be

addressed. The authors suggested that the coping process goes through three phases. Coping begins when an individual cognitively appraises that a stressful event will have an impact on her or him (primary appraisal). When this appraisal occurs, the individual then examines and determines possible outcomes and what action can be taken to deal with the stressor (secondary appraisal). Carver, Scheier, and Weintraub (1989) added the implementation of coping responses as the final phase. In this phase, the individual goes through the process of actually executing that response. Lazarus and Folkman (1985) suggested that process theory views the two components of cognitive appraisal (primary and secondary appraisal) as being situationally specific in that an individual's cognitive appraisal changes as a function of the stressful situation encountered and the perceived variety of resources available to deal with the situation.

2.2.2 Research on Coping Strategies

Researchers acknowledge the conundrum of understanding women's coping in the face of IPV. Although coping may help them manage and understand their situations, these efforts may increase their ability to tolerate abuse, and therefore make them more likely to stay in their relationships and risk further abuse (Smith, Murray, & Coker, 2010). In general, research confirms the multiplicity of coping strategies women use to cope with being abused by their intimate partners. Oftentimes, strategies overlap depending on the unique aspects of the situations women face. A battered woman's ways of coping must be understood first and foremost in relation to her context of survival (Dutton, 2009). Studies on IPV suggest that contextual factors influencing coping and survival include sociodemographic factors and prior history of trauma and abuse. Sociodemographic factors may include socioeconomic status, gender, prejudice, stigmatization, family support, partner's use or abuse of alcohol and chemical substances, and marital status. Prior history of trauma is also related to a woman's increased risk

of experiencing IPV. For women exposed to IPV, childhood abuse has also been shown to increase the risk of PTSD (Dutton. 2009).

In his review of the current research on coping, Morgan (2008) found that people process information about their environments in different ways. He gave the example of drivers who may react differently to a traffic light turning yellow as they approach the intersection. He explained that some drivers will calmly brake and come to a stop; other drivers will be frustrated by the yellow light and accelerate in order to get through the intersections. The environmental circumstance is the same, but the two sets of hypothetical drivers respond to the situation differently. The same is true of how people manage stressful life events. How people evaluate any particular stressor will have implications for how they choose to cope with it.

Coping can also be viewed within the context of personality traits such as positive or negative affectivity (Zeidner, M., 2006), optimism, neuroticism, and extraversion, situational factors, and the ongoing transaction between the person and the environment (Morgan, 2008). Social support and marital satisfaction have likewise been consistently positively related to one's ability to cope with stressors (Morgan, 2004). Individuals who perceive a stressful event as less threatening and have higher self-efficacy view the event as challenging and report better psychological adjustment (Morgan, 2008).

Researchers have attempted to organize coping strategies (and styles) into different categories, thus using different terminology, oftentimes with similar definitions. As such, there has been a wide variability in the number of coping dimensions described; however, Waldrop and Resick (2004) argued that there are two primary descriptive factors that emerge repeatedly across studies on coping. The first is the distinction between *approach* versus *avoidance* coping, also described as *active* versus *avoidant coping* and *engagement* versus *disengagement* coping.

The approach and avoidance strategy classification indicates whether the individual makes attempts to change the situation or distance herself from the stressor as a way to reduce negative outcomes.

In a study done with undergraduates (*N*=125), Carver and Scheier (1994) determined an additional classification of coping: *problem-focused coping* and *emotion-focused coping*. Problem-focused coping strategies aim to remove the threatening event or diminish its impact. Emotion-focused coping strategies aim to reduce the negative *feelings* that arise in response to the threat. They argued that, although these two categories are easily distinguished in principle, they typically co-occur and their effects on mental health outcomes can be difficult to disentangle. For example, emotion-focused coping can facilitate problem-focused coping by removing some of the distress that can hamper problem-focused efforts; similarly, problem-focused coping can render a threat less forbidding, thereby diminishing distressing emotions.

In an effort to examine the relationships between coping and psychopathology, Endler, Parker, and Butcher (2003) conducted a study with a sample of adult male applicants (*N*=167) for the position of airline pilot with a major American airline. Measures used were the Minnesota Multiphasic Personality Inventory (MMPI-2) and the Coping Inventory for Stressful Situations (CISS). They found a strong positive association between emotion-oriented coping strategies and various measures of psychological distress. Task-oriented coping strategies were unrelated psychological distress. This study suggested that the use of emotion-focused coping strategies was associated with increased psychopathology.

Individuals vary in their use of coping strategies. Some individuals tend to use the same coping strategies regardless of the specific situational demands, while others draw on a variety of coping strategies to deal with challenges. In the context of IPV, a woman may have a preference

for a particular strategy in a particular situation. For example, she may choose to use approach strategies in the workplace, while choosing avoidance strategies to cope with her severely abusive husband (Morgan, 2004). Her work environment may be an environment in which she can use more proactive strategies to accomplish her tasks. It might be encouraged or expected of her to do so if she wants to keep her employment or advance in her career. If she is living within an abusive environment, she may not feel empowered enough to confront and change the environment without risks to her safety or that of her children.

Morgan (2004) suggested that a good strategy–situation fit is related to adaptive coping outcomes such as psychological well-being, physical well being, social adaptation, and reduced strain symptoms. Research investigating the process underlying coping flexibility reveals two distinct appraisal processes: differentiation and integration. Differentiation refers to the ability of an individual to view a situation from many perspectives before deciding on a coping strategy. Integration refers to a person's ability to perceive the advantages and disadvantages of pursuing one course of action, or of choosing one coping strategy over another. Individuals high in coping flexibility are found to engage in both of these cognitive processes. Family of origin experiences, personality traits, socioeconomic and educational factors, and social support or spiritual orientation could also contribute to the ways in which a woman copes with intimate partner violence.

Clearly, there are varying results from studies on coping. Coping has been researched within numerous contexts and with various populations. Results can be replicated or varied depending on the sample populations, the context within which coping occurs, and the traits that determine an individual's use of coping strategies.

2.2.3 Coping with Intimate Partner Violence and Mental Health Outcomes

Research emphasizes the importance of considering multiple factors that influence adaptation and coping with IPV, including characteristics of the violence, the individual, and the post-trauma recovery environment (Krause et al., 2008). Kocot and Goodman (2003) found that the little research that has been done on women's coping with IPV suggests that the types of strategies women use to handle the violence influence their mental health. Women who suffer abuse in intimate relationships are at risk for many negative psychological outcomes, such as elevated levels of depression, suicide attempts, anxiety, and posttraumatic stress disorder (Carlson, McNutt, Choi, & Rose, 2002). They are also likely to engage in a multitude of coping strategies to survive or end the abuse in their relationships or to leave their relationships.

Some limited empirical evidence examines the specific associations between psychological outcomes and particular ways of coping among women who have experienced IPV (Waldrop & Resick, 2004). Taft et al. (2007a) conducted a longitudinal study examining the associations between relationship abuse, coping variables, and mental health outcomes among a sample of women (N=61) recruited from shelters and non-residential community agencies who had experienced IPV. Their results showed that sexual aggression towards the women from their intimate partners was a stronger predictor of poorer mental health outcomes for these women than was physical assault. Engagement coping strategies were generally predictive of positive mental health, and disengagement coping strategies were generally predictive of poorer mental health. Results highlighted the complexity of the associations between different forms of relationship abuse, coping strategies, and mental health outcomes among women who have experienced IPV.

Kocot and Goodman (2003) investigated the role of social support as a moderator of the relationship between problem-focused coping and PTSD and depression among low-income African American women who had experienced IPV. Using correlational and multiple regression analyses, they showed that problem-focused coping was associated with mental health symptoms, including higher levels of PTSD and depression symptoms, particularly among women without supportive social networks. These results are consistent with other research indicating the importance of accessible support available to women to strengthen and empower them towards positive mental health.

In another longitudinal study examining correlates of problem-focused and emotion-focused coping, including abuse-related factors, socioeconomic and social coping resources, and childhood trauma variables among a sample of women (*N*=388) who had experienced IPV and who had been recruited from shelters and non-residential community agencies, Taft et al. (2007a) revealed significant results. The measures used in the study included the Conflict Tactics Scale-2, the Coping Strategies Inventory, the Beck Depression Inventory, the State-Trait Anxiety Inventory, and the Posttraumatic Diagnostic Scale. They examined associations between problem-focused coping skills and emotion-focused coping skills, and psychosocial outcomes such as depression, hopelessness, and anxiety, and peritraumatic dissociation symptoms, also known as PTSD. Taft et al. (2007a) defined problem-focused coping skills as responses that directly alter or resolve the stressful situation, while emotion-focused coping skills involve attempts to manage and regulate one's emotional reactions to the stressor. They found strong associations between abuse-related factors, social coping resources, childhood trauma variables, and problem- and emotion-focused coping. Abuse frequency, psychological violence, and severity of the violence were strongly associated with emotion-focused coping for peritraumatic

dissociation. Coping resource variables such as tangible support, appraisals of support, and greater sense of belonging were strongly associated with problem-focused coping. The authors suggested that a strong social support network has an empowering effect on women and provides greater access to resources that facilitate further use of problem-focused coping and fewer symptoms of peritraumatic dissociation. Women engaged in both problem-solving and emotion-focused coping simultaneously in an effort to deal with perceived stressors. Particular behaviours may be seen as more proactive and problem-focused (confrontational coping, problem solving, information seeking) and other behaviours may be seen as emotion-focused (distancing and self-control). In conclusion, results suggested that coping strategies used by women who have experienced IPV are complex and multi-determined and warrant further exploration.

2.3 Posttraumatic Stress Disorder

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV®-TR) (American Psychiatric Association, 2000) has long been considered a standard framework for diagnosing mental disorders within the mental health care field. The following will present the diagnostic criteria of PTSD.

According to the DSM-IV®-TR, "The essential feature of PTSD is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate" (American Psychiatric Association, 2000, (p. 463).

The manual further states that traumatic events that individuals experience include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe vehicular accidents, or being diagnosed with a life threatening illness. For the population of children, sexually traumatic events may include developmentally inappropriate sexual experiences without the threat of injury or the actual violence. Individuals who witness or observe events of serious injury or unnatural death of another person(s) due to acts of violence, accidents or disasters or witnessing a dead body or body parts." (American Psychiatric Association, 2000, (p.463).

2.3.1 Posttraumatic Stress Disorder Symptoms

There are various ways in which traumatic events can be experienced: recurrent and intrusive recollections of the event, recurrent distressing dreams, and dissociative states sometimes referred to as "flashbacks," intense psychological distress, or physiological reactivity to triggering events. Another indication of the presence of PTSD includes avoidance of the stimuli associated with the trauma. The traumatized individual usually makes deliberate efforts to avoid thoughts, feelings, or communication surrounding the traumatic event. Avoidance of activities, situations, or individuals who arouse the memories of the traumatic event or avoidance of reminders could include amnesia of crucial parts of the event. "Psychic numbing," also referred to as "emotional anesthesia" or diminished responsiveness to the external world is often experienced soon after the traumatic event. Traumatized individuals often report decreased interest or involvement in previously enjoyed activities, feelings of detachment or estrangement from other people, or reduced ability to feel emotions (i.e., those associated with intimacy, tenderness, and sexuality). Experiencing a sense of a foreshortened future (e.g., not expecting to

get married, or to have children, a career, or a normal life span), persistent symptoms of anxiety, or arousal not present prior to the trauma could lead to difficulty in falling or staying asleep due to recurrent nightmares reliving the trauma, hypervigilance, exaggerated startle response or reaction, consistent irritability or outburst of anger, and/or difficulty concentrating or completing tasks (Liebschutz et al., 2003).

Asmundson, Stapleton, and Taylor (2004) elaborated that, in order for symptoms to satisfy criteria for a diagnosis of PTSD, a person must be exposed to a traumatic event with actual or perceived threat *and* they must (a) experience intense fear or helplessness, (b) have at least one intrusion symptom, at least three avoidance and/or numbing symptoms, and at least two arousal symptoms, (c) must be bothered by these symptoms for one month or more, and (d) must experience significant distress or impairment in social, occupational, or other functioning.

2.3.2 PTSD and Gender

In general, women experience different types of trauma than men. Women are more likely to be exposed to rape, sexual molestation, childhood parental neglect, and physical abuse, whereas men are more likely to be exposed to life-threatening accidents, fires, floods, natural disasters, combat, physical attack, or the injury or death of another (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). These qualitative differences in the nature of the trauma experienced likely impact type and extent of symptoms reported by men and women (Deering, Glover, Ready, Eddleman, & Alarcon, 1996). For instance, while there is some evidence that symptoms of Generalized Anxiety Disorder (GAD) are associated with most types of trauma, panic symptoms may be linked to unpredictable and sudden events (e.g., rape), and somatic symptoms may be the result of physically brutal events (Deering et al., 1996).

According to Kimerling, Ouimette, and Wolfe (2002), biological differences between men and women may moderate the impact of trauma exposure and the expression of PTSD symptoms. Women develop PTSD at a rate twice that of men. The authors suggested that women show greater chronicity of PTSD symptoms than do men. In their review of sex-differences in behavioural, neurochemical, neurobiological, and pharmacological findings collected from several different animal studies, Yehuda (2002) confirmed that women generate a higher plasma corticosterone (stress induced hormone) concentration level in their bodies as a response to stressful situations than men. Gender is also a major factor in the type of trauma exposure experienced by the individual, the social relationships that mediate the impact of exposure, and the systems of meaning into which the traumatic event is encoded. Gaining a deeper understanding of the specific effects of sex and gender in the prevalence, etiology, assessment, diagnosis, and treatment of PTSD may be impossible. However, awareness and consideration of gender issues in research and service delivery can enhance our knowledge base of PTSD and our skills and abilities to provide assistance to individuals who are traumatized (Kimerling et al., 2002).

Most community-based epidemiological studies suggest that PTSD is found among women at approximately twice the rate as in men, and tends to take a more chronic course for women; neither the types of events experienced nor perceptions of threat fully account for these effects. The risk for PTSD among women begins around adolescence and continues throughout middle age. Further research is required to determine whether the relative comparability of men and women in late life is an aging or cohort effect (Norris, Foster, & Weisharr, 2002).

2.3.3 PTSD and Emotion-Focused Coping

Emotion-focused coping is defined as actions intended to help the individual assuage psychological distress and reduce negative affect associated with experiencing stressors (Lilly & Graham-Bermann, 2010). It is a way of coping used to manage emotions that lead to distress rather dealing with the stressor directly (Carver et al., 1989). Praying, crying to release feelings, or positive reappraising are all considered emotion-focused coping strategies aimed at regulating distress associated with the violence. Women in abusive relationships who may not have the resources or ability to leave the relationship may utilize these strategies. In such cases, emotion-focused coping may be the only method available for coping with the stress of violence.

Nonetheless, studies have shown that emotion-focused coping has been associated with negative mental health states such as depression, reduced well-being, anxiety, and a higher level of posttraumatic stress symptomatology among women who have been exposed to IPV (Taft et al., 2007a; Zeeshan, Strauss, Smyth, & Rose-Rego, 2002). In their study examining the relationships between exposure to violence, coping style, and PTSD symptoms among IPV survivors recruited through domestic violence shelters, social service agencies, doctors' offices, and courts in southeastern and central Michigan, Lilly and Graham-Bermann (2010) found a positive correlation between emotion-focused coping, PTSD, and IPV exposure.

In a correlational study examining the associations between coping, combat exposure, and PTSD among 218 United States National Guard veterans deployed overseas, Rodrigues and Renshaw (2010) found that emotion-focused coping was directly related to both the severity of combat exposure and post-deployment PTSD symptoms. Importantly, they also found that the severity of combat exposure acted as a moderator of the relationship between emotion-focused

coping and PTSD. These findings further indicate that the type and severity of trauma may moderate the association of coping psychological outcomes, and these associations may not be linear but rather curvilinear.

Problem-focused strategies are generally considered more adaptive than emotion-focused strategies. However, a qualitative study by Smith et al. (2010) on coping strategies used by 10 women seeking services in shelters in the United States revealed that the assessment of coping becomes more complicated when applied to women who have experienced IPV. For example, the problem-focused coping strategy of women standing up for themselves or confronting the abusive partners is considered positive. However, they found that "when one of the women in our study stood up for herself, she was escorted into her home at gunpoint" (p. 24) by her intimate partner thus increasing her risk of further abuse. At such times, emotion-focused coping may be the only resource available to women who are living with IPV.

2.4 Summary

Episodes of intimate partner violence are virtually always destructive in some manner and can be terrifying. Women's emotions following an episode of such violence will likely be intensely negative (Downs, 2001). Women who have experienced intimate partner violence suffer diminished mental health. Posttraumatic stress disorder is among one of the more deleterious effects of IPV (Taft et al., 2007b). A broad body of research has established that coping responses used to face adversity play an important role in the psychological adjustment process (Calvete, E., Corral, S., & Estevez, A., 2008). Literature on coping produces varied results suggesting that coping is a highly complex and multi-dimensional process. However, the majority of coping literature confirms that coping strategies can be divided into two categories:

emotion-focused and problem-focused. In fact, the distinction between the two strategies is central to coping theory (Stanton & Franz, 1999).

Research over the past 30 years has dispelled myths characterizing IPV survivors as uniformly passive in response to the violence. In fact, women who have experienced IPV respond to violence in a variety of ways. Relatively little is understood about how a woman's response to the violence in her life affects her mental health (Kocot & Goodman, 2003).

This study seeks to examine the relationship between the use of emotion-focused coping strategies and symptoms of posttraumatic stress as a health outcome among a sample of women who have been exposed to IPV in Saskatchewan, Alberta, and Manitoba. This study recognizes that it is important to examine factors that may be associated with potentially effective and ineffective forms of coping.

CHAPTER 3: METHODOLOGY

This chapter outlines the methodology used in the present study including how data were collected, and participants recruited. Information on ethical considerations, how data were cleaned, how missing data were managed, and research instruments are also provided.

3.1 The Healing Journey Project

The relationship between emotion-focused coping and posttraumatic stress in a sample of women exposed to intimate partner violence was explored using a non-experimental research design. This research is a secondary analysis of quantitative data collected for the "Healing Journey: A Longitudinal Study of Women Affected by Intimate Partner Violence" project funded by the Social Sciences and Humanities Research Council, Community–University Research Alliances grant program. The Healing Journey is a Canadian tri-provincial study (Manitoba, Saskatchewan, and Alberta) that incorporates the partnership of multiple university and community-based agencies engaged in anti-violence research. It is the first longitudinal study of intimate partner violence that affects women in Canada. The aim was to recruit at least 600 women, 200 from each province.

This first of seven waves of data collection began in September 2005, and concluded in 2010. The Healing Journey sought to gain insight into the experiences of women in the Prairie Provinces who have lived through intimate partner violence. Both quantitative and qualitative data were collected in four broad areas: demographic information, service utilization, health and mental health, and parenting.

3.2 Participant Recruitment

The participants for the study were women who were recruited primarily through service provider agencies and probation services throughout Saskatchewan, Manitoba, and Alberta. The

directors of the agencies or their designates, along with probation officers, were sought to facilitate the recruitment process. A script of participation criteria, provided to the directors and their designates, was approved included the following:

1. Having experience with intimate partner violence with the last incident of physical abuse occurring no earlier than January 2004;
2. Not being in a crisis situation;
3. Having a high likelihood of staying in the study for the full 3 ½ years; and
4. Not having any serious or debilitating mental health issues.

Although seven waves of data have been collected, data from Wave 1 and Wave 2 were required for the purposes of this study. A total of 670 women from the Prairie Provinces provided Wave 1 and 2 survey data.

3.3 Ethical Considerations

This research has been granted ethics clearance from the University of Saskatchewan Ethics Research Board. Permission from the Healing Journey Project Review Committee to use the data for the current study was also granted. As a secondary analysis, the current study and analyses fall within the scope of the ethics clearance granted to the larger Healing Journey project, as the current study focuses on the relationship between IPV experiences, coping, symptoms of post traumatic stress. Therefore, further ethical clearance was not required.

3.4 Cleaning the Data and Missing Data

Leong and Austin (2006) suggested that prior to embarking on preliminary analyses, screening of participant responses for obviously invalid data and dealing with missing data must be addressed. The data were checked and found it to be clean; there was no evidence of invalid or missing data.

There is no universally accepted guideline for how much missing data is too much (Leong & Austin, 2006). Considerations for missing data were made by members of the larger project. As such, the questions/variables for the Composite Abuse Scale, coping measure, and PTSD Checklist provided options that were either "not applicable," "don't know," or "missing response." Some of the items or questions of each scale were not answered by all the participants; thus, the above-mentioned options contributed to "missing response" for the three main outcomes. The missing responses were calculated as deleted cases and not put into the analysis. The *N* value for correlational analysis for the Composite Abuse Scale was *N*=577, Emotion-Focused Coping Strategy was *N*=573 and PTSD Checklist was *N*=576. The value for *N* was reduced to the lower value when correlation analysis was performed. The CAS showed a range of 0.0% to 4.3% missing on individual items, and a total of 13.9% missing when summing the scale as a whole value. The EFCS showed a range of 0.4% to 8.1% missing on individual items, and a total of 14.5% missing when summing the scale as a whole value. The PTSD Checklist showed a range of 11.2%–12.1% missing on individual items, and a total of 14.0% missing when summing the scale as a whole value. Given that participation was voluntary, participants were free to not answer questions and/or terminate their participation at any time. The pattern of missing responses suggests that if a participant did not respond to one question, they did not respond to the rest of the items. It was decided to examine the overall numbers of "missing" information. This was found to be reasonable (<15% of data) given that the number of participants was 670 *(N*=670*)*, which is considered a robust number for analysis (Leong & Austin, 2006).

3.5 Research Instruments

The Healing Journey research project made use of a Health Questionnaire packet composed of six topics related to health: demographic and history of abuse, general health, functional health status, mental and emotional health, stress, sexual health, alcohol and drug screening, and health service utilization. The Health Questionnaire packet contained standardized psychometric instruments as well as other questionnaires derived mainly from the Canadian National Population Health Survey (2004). The current project made use of data derived from the first and second wave of questionnaires from Saskatchewan, Alberta, and Manitoba contingency *(N*=670*)*. More specifically, data were extracted from the demographic and history of abuse questionnaire, the Composite Abuse Scale (Hegarty, 2005), the Emotion-Focused Coping Strategy index (Bauman, & Haaga, & Dutton, 2008) and the Posttraumatic Stress Disorder Checklist (Weathers, Litz, Herman, Huska, & Keane, 1993).

3.5.1 The Composite Abuse Scale

The Composite Abuse Scale (CAS) is a relatively robust standard for identifying IPV in primary care settings (Eldridge, Feder, & Sohal, 2007). The original scale was developed in 1995 using items from previously existing measures such as the Conflict Tactics Scale (CTS), the Revised Conflict Tactics Scale (CTS2), the Psychological Maltreatment of Women Inventory (PMWI), the Index of Spouse Abuse, the Measure of Wife Abuse, and the Abuse Risk Inventory for Women (Bush, Hegarty, & Sheehan, 2005). It originally contained 74 items comprising four subscales and was validated on a sample of nurses *(N*=427*)*. Further validation on a sample of general practice patients *(N*=1896*)* and emergency department patients *(N*=345*)* has resulted in the current 30-item scale (Hegarty, 2007).

The CAS is designed to measure all types of abuse, frequency of abuse, and consequences of the abuse using a five-point Likert scale, whereby higher scores indicate greater severity of IPV (Appendix D). The CAS contains four subscales that measure severe combined abuse, emotional abuse, physical abuse, and harassment (Bush, Hegarty, & Sheehan, 2005; Hegarty, Schonfeld, & Sheehan 1999). Hegarty (2007) defined the Severe Combined Abuse factor as having eight items that represent severe physical abuse items, all sexual abuse items, and physical isolation aspects of emotional abuse. The Emotional Abuse factor has 11 items that include verbal, psychological, dominance, and social isolation abuse items. The Physical Abuse factor has seven of the less severe physical abuse items and the Harassment factor has four items that are about actual harassment. Hegarty (2007) further suggested that the strength of the scale is the ability to measure different types and severity of abuse, although a limitation is the reduced number of sexual abuse items.

The CAS demonstrates strong convergent and limited discriminant validity in relation to self-rating of abuse and sociodemographic variables. Convergent and discriminant validity together are considered as interlocking measures of constructs or subsets of construct validity. Convergent validity, as defined by Thompson, Basile, Hertz, and Sitterle (2006), is the extent to which responses on a scale are correlated to responses on another scale that assesses a similar underlying construct. In other words, construct validity tests whether constructs that are to be related are, in fact, related. Hegarty et al. (2005) suggested that the convergent validity in the CAS correlates well with other variables with which partner abuse should theoretically be associated. For example, previous evidence has shown that more frequent severe abuse is associated with women who have left their partners (Hegarty et al., 1999). The strength of the CAS's discriminant validity is evidenced as a measure that is not correlated with irrelevant

variables. This is to say that constructs that should have no relationship do not, in fact, have any relationship.

The CAS has the unique ability to measure and classify IPV according to type and severity of abuse. The four CAS subscale factors exhibit good internal reliability, meaning that the items reflect a common underlying construct. The internal consistency reliability was 0.85 or higher and for the 0.9 for the majority of subscales (Hegarty et al., 1999). Fiddell and Tabachnick (2007) suggested that often a score of 0.80 is the desired power, expected in assessment of effect and a sign of acceptable reliability. This suggests a strong consistency of the results delivered in the CAS test, ensuring that the various items and subcategories in the CAS measuring the different constructs produce consistent scores.

Hegarty (2007) suggested the CAS is to be scored by summating the frequency scores without any weighting of the 30 items. The 0–5 Likert scale response to each item gives a possible score for each subscale of Severe Combined Abuse (0–40), Physical Abuse (0–35), Emotional Abuse (0–55), and Harassment (0–20). The instrument is designed to indicate higher scores with severity of abuse. The first category is all women who have experienced at least one episode of severe combined abuse with any of the other dimensions of abuse or by itself. The second category is women who have experienced physical abuse combined with emotional abuse and/or harassment. The third category is women who experienced at least one episode of physical abuse *only*. The fourth category consists of those who have experienced emotional abuse and/or harassment *only*. These four types of abuse allow for researchers to examine associations between the different types of abuse women experience in their intimate partnerships (Hegarty et al., 2005).

3.5.2 Emotion-Focused Coping Strategies

The rationale behind developing the coping scale for the Healing Journey project has been described in part. Exhaustive research for the coping questionnaire produced only two journal articles. The authors of the instrument reported that the Emotion-Focused Coping Strategy (EFCS) instrument was developed from the Strategies for Dealing with IPV Effects Questionnaire (Bauman, Haaga and Dutton, 2008). The EFCS questionnaire is a list of 29 strategies Bauman et al. 2008 suggested are utilized by women to cope with feelings associated with IPV. The questions identify items that focus on the personal thoughts and feelings of the person who is coping with the violence. For example, the EFCS asks respondents if they ever "tried to figure out why he was violent or abusive," "tried to see the good parts of him," "thought about trying to kill myself," and "exercised more to relieve the stress and tension" in order to deal with the feelings associated with the violence. The items for the EFCS were originally generated from a review of literature on women's use of strategies in situations where IPV is present, from the original research team's own clinical and forensic experiences with women abuse, and from focus groups with advocates and women who had experienced abuse in their intimate partnerships.

The instrument consisted of a two-part response. The first response to each strategy was a *yes* or *no* response. A *no* response was scored with a 0 and a *yes* response was scored with a 1. The second part evaluated the subjective outcomes of coping strategies using a Likert-type scale rating the helpfulness of each endorsed strategy from 1 (*not at all helpful*) to 5 (*very helpful*). Therefore, when a strategy was reported with a *yes*, subsequently a rating of helpfulness from 1 to 5 was asked. Cronbach's alpha for the helpfulness ratings was 0.89 (Bauman et al., 2008).

3.5.2.1 Coping Measure Utilized in the Healing Journey Project

The dataset and original questionnaires for the Healing Journey study showed a 40-item list of strategies used for coping. After careful screening for accuracy and any departures from the original EFCS instrument, several revisions were made to better suit the needs of the Healing Journey's study. The similarities with the EFCS were there were 28 out of 29 questions from the original Emotion-Focused Coping Strategy instrument that were used in the Healing Journey's study, and the two-pronged responses of yes/no and degree of helpfulness were also incorporated. The difference between the questionnaires was that 12 more questions of the same nature were added to make a total of 40 questions.

The wording for the content of the questions was changed from the original EFCS. For example, the original instrument states, "prayed for guidance and strength or meditated" and the Healing Journey's questionnaire states "prayed to feel better after the abuse." Reference to gender from "he", "men" or "him" changed to "partner," and the one question or variable of "used alcohol or street drugs to relax or calm myself" was not used in the Healing Journey's study. Appendix B provides a list of the questions used in the original EFCS and the questions from the Healing Journey project.

3.5.3 Posttraumatic Stress Disorder Checklist and Subscales

The PTSD Checklist (PCL) is one of the gold standards for facilitating the diagnosis of PTSD (Blanchard, Jones-Alexander, Buckley, & Ferneries, 1996). The PTSD Checklist is used for assessing PTSD and posttraumatic stress symptoms (PTSS) for a population or individuals who have experienced trauma. The PTSD Checklist is a 17-item self-report rating scale that parallels the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (2000) (DSM-IV-TR) diagnostic criteria for PTSD. The PTSD Checklist measures three clusters of PTSD symptoms according to the DSM-IV-TR criteria, namely intrusion (five

items in the PTSD Checklist), avoidance and/or numbing (seven items in the PCL), and hyperarousal (five items in the PCL). Elklit, Armour, and Shevlin (2009) reported that the symptom groupings have since undergone a number of changes. Asmundson et al. (2004) contended that there is mounting evidence to support the position that the PTSD symptom clusters outlined in the DSM—specifically the lumping together of avoidance and numbing symptoms—may not provide the best conceptualization of PTSD symptoms. They suggest that the results of a large majority of factor analytic studies, both exploratory and confirmatory, indicate that avoidance and numbing are distinct and so may represent distinct causal mechanisms without which the distinct contribution of each participant's response is not given full attention.

This study chose to analyze the PCL with the established *four* factorially derived PTSD subscales consisting of intrusion, avoidance, numbing, and arousal (Asmundson et al., 2004; Cook, Jakupcak, Rosenheck, Fontana, & McFall, 2009). The intrusion subscale consists of symptoms associated with reliving the trauma, such as nightmares or intrusive thoughts of trauma. The avoidance subscale is associated with strategic efforts to escape trauma-associated memories (e.g., avoiding talking about trauma). Numbing symptoms are believed to be mediated by automatic mechanisms, involving loss of interest, detachment from others, and restricted positive affect or narrower range of emotional expression. Finally, the arousal subscale involves a range of agitated states, including feelings of irritability, difficulty concentrating, and hypervigilance (Cook et al., 2009).

The PCL questionnaire uses a 0–5 Likert scale indicating the degree to which the respondents have been negatively impacted by a particular symptom from 1 (not at all) to 5 (extremely). Higher scores on the PCL indicate greater posttraumatic stress symptomatology.

The Posttraumatic Stress Checklist is an efficient diagnostic measure of the possible presence of PTSD because it is easy to administer (approximately five minutes) and easy to score. The checklist can be used as a continuous measure of PTSD symptom severity by summing scores across the 17 items (Weathers et al., 1993). It can also be used to derive a PTSD diagnosis by considering a score of 3 (moderately) or greater as a symptom.

With the strength and volume of research about the use of four (4) subscales instead of three (3), this study chose to make use of four subscales. It is hoped that by using four instead of three subscales, we can extend our understanding of the basic mechanisms of posttraumatic stress acknowledging the fundamental complexity of women's experiences.

3.6 Levels of Measurements

The Composite Abuse Scale and Posttraumatic Stress Checklist are Likert Scales. The original Emotion-Focused Coping Questionnaire consists of 29 emotion-focused coping items. The first part of each response to each item consisted of binary yes/no responses; the second part measured the subjective outcomes of coping strategies made up of a Likert-type scale to rate the helpfulness of each strategy ranging from 1 to 5. The Healing Journey project utilized 28 out 29 questions from the Emotion-Focused Coping Strategy. The one question eliminated for the Healing Journey project was "used alcohol or street drugs to relax or calm myself." Given that this research is not exploring patterns and correlation between prevalence of use of emotion-focused coping strategies and perceived helpfulness, only the first part of the each response, i.e., yes/no responses, were explored, thus informing the "use" of the coping strategies. Nonetheless, an inferential analysis for the "helpfulness" will be included as a point of interest and observation.

This analysis seeks to explore an association between intimate partner violence and symptoms of posttraumatic stress and an association between intimate partner violence and the use emotion-focused coping, and an association between the use of emotion-focused coping and symptoms of posttraumatic stress. Hypothesis one states there is no relationship between exposure to violence as measured by the Composite Abuse Scale (CAS) and symptoms of posttraumatic stress as measured by the Posttraumatic Stress Checklist (PCL) among women who have experienced IPV. The CAS and subscales were the independent variable(s) and the PCL and subscales were the dependent variable(s) used in the analysis. The second hypothesis states there is no relationship between exposure to violence as measured in the CAS and use of emotion-focused coping strategies as measured in the Emotion-Focused Coping Strategies (EFCS). The CAS was the independent variable and the EFCS was the dependent variable. The third hypothesis states there is no relationship between the use of emotion-focused coping strategies as measured in the EFCS and symptoms of posttraumatic stress as measured in the PCL. The EFCS was the independent variable and the PCL and subscales were the dependent variable(s).

3.7 Data Analysis

Descriptive and inferential statistical analyses were utilized for the present study using SPSS Version SPSS 18.0 (2009). The analysis has 670 participants *(N*=670*),* the CAS (and four subscales), Emotion-Focused Coping Strategy, Posttraumatic Stress Checklist (and four subscales). In order to meet the criteria for correlational analysis, steps were taken to ensure that the assumptions for the analysis were met. Normal Q-Q plots for all variables do not show any serious departures from normality. Therefore, we were able to use all outcome variables without any transformations. See Appendix A.

Descriptive statistical analysis of the demographic variables were as similar as possible to those Bauman et al. (2008) used in the development of their Emotion-Focused Coping Strategy scale. The rationale for using the same demographic variables was to enhance consistency in this exploratory analysis of the data. As such, a frequency distribution of age, ethnicity, level of education, employment, income, sources of income—specifically social assistance—, child support and spousal support, marital status, and number of children (if any) was collected.

The demographic characteristics of the sample were examined using frequencies and percentages for consistency with the methods used in the original use of the Emotion-Focused Coping Strategies reference. The relationship between the Composite Abuse Scale, symptoms of PTSD, and Emotion-Focused Coping Strategies were assessed using the Pearson correlation. Pearson correlations were used to analyze bivariate associations between the variables of interest and the outcome variable of PTSD and Emotion-Focused Coping Strategies. For the three hypotheses, inferential statistical tests were established with an alpha probability of .05 to ensure reasonable guarantee against an error in rejecting the null hypothesis or Type I error, thus ensuring a certain measure of consistency in producing statistical power for all the tests.

Hill and Lewicki (2007) explained that the significance level (*p*-value) of a result is the probability that the observed relationships (e.g., between variables) or a difference (e.g., between means) in a sample occurred by pure chance, and that in the population from which the sample was drawn; no such relationship or differences exist.

Hill and Lewicki (2007) further described the *p*-value as representing decreasing index of the reliability of a result. The higher the p-value, the less we can believe that the observed relation between variables in the sample is a reliable indicator of the relation between the

respective variables in the population. Specifically, the *p*-value represents the probability of error that is involved in accepting our observed result as valid or "representative of the population."

Typically, results that yield $p < .05$ are considered significant, and $p < .005$ or $p < .001$ levels are considered "highly" significant, thus it can determine whether to accept or reject the null hypothesis that suggests that sample observations result purely by chance.

Effect size (ES) is a statistical parameter that measures the strength of the relationships between two variables in correlational analysis. Tabachnick and Fidell (2007) suggested that ES reflects the proportion of variance in the dependent variable that is associated with levels of an independent variable. Hill and Lewicki (2007) stated that ES takes the value zero when the null hypothesis is true, and any other specific non-zero value when the null hypothesis is false. This way, the ES serves as an index of degree of departure from the null hypothesis. The quantity of *r*, also known as the linear correlation coefficient, measures the strength and the direction relationship between two variables sometimes referred to as Pearson product moment correlation coefficient. The value *r* is such that $-1 \leq r \leq +1$ suggesting that positive (+) and negative (-) linear correlations. The ES for this analysis was determined based on Cohen's (1988) guidelines for the social sciences: small ES, r=0.1–0.23; medium ES, r=0.24–0.36; large ES, r=0.37 or larger.

Tabachnick and Fiddell (2007) stated that the null hypothesis assumes that any kind of difference or significance is due to chance or the absence of statistical significance existing in a set of given observations. Put another way, it attempts to show that there is no variation between variables, or that a single variable is no different than zero (0). Thus, the null hypothesis applied to the hypotheses in this study would state that there is no relationship between exposure to higher rates of violence as measured in the CAS and higher rates of reported symptoms of

posttraumatic stress as measured in the PCL. There is no relationship between greater exposure to violence as measured in the CAS and higher use of emotion-focused coping strategies as measured in the EFCS. Finally, there is no relationship between higher use of emotion-focused coping strategies and more self-reported symptoms of posttraumatic stress as measured in the PCL.

3.8 Summary

In summary, the first hypothesis in this study stated that there is no relationship between exposure to violence using the Composite Abuse Scale (CAS) and symptoms of posttraumatic stress using the Posttraumatic Stress Checklist (PCL). The second hypothesis stated that there is no relationship between exposure to violence (CAS) and use of emotion-focused coping strategies using Emotion-Focused Coping Strategy (EFCS) index. The final hypothesis stated that there is no relationship between emotion-focused coping (EFCS) and symptoms of posttraumatic stress (PCL). Descriptive and inferential statistics were used as a means of gaining more information on the demographics of the participants in the study. A non-experimental research design method utilizing a correlational analysis was used.

CHAPTER 4: RESULTS

This chapter presents the results of the data analysis investigating the relationship between emotion-focused coping and posttraumatic stress among women who have been exposed to intimate partner violence as measured by participants' scores on the Composite Abuse Scale (Hegarty, 2007), Emotion-Focused Coping Strategies index, and Posttraumatic Stress Checklist. The correlational analysis will test the three hypotheses using the null hypothesis significance testing stating that:

- There is no relationship between exposure to violence as measured in the Composite Abuse Scale (CAS) and symptoms of posttraumatic stress as measured in the Posttraumatic Stress Checklist (PCL) among women who have experienced intimate partner violence (IPV).
- There is no relationship between violence as measured in the CAS and use of emotion-focused coping strategies as measured in the Emotion-Focused Coping Strategies (EFCS) index.
- There is no relationship between use of emotion-focused coping strategies as measured in the EFCS and more self-reported symptoms of posttraumatic stress as measured in the PCL.

4.1 Sample and Subsample Descriptive Statistics

Participants (*N*=670) consisted of women from Saskatchewan, Manitoba, and Alberta. Descriptive statistics for the demographic profile and history of abuse are presented in Table 1 and 2 respectively. The majority of participants (*N*=324 or 48.6%) were 36 years of age or older. The mid-range age group (*N*=224; 33.6%) was between the ages of 26 and 35, and *N*=119 (17.8%) were between the ages of 17 and 25. Education levels were marked by 42.7% (*N*=285)

with Grade 11 or lower, to the lowest numbers of 17.4% (*N*=116) participants with some postsecondary education. Regarding employment status, the majority of women, *N*=405 (61.7%) reported being unemployed, *N*=138 (21.0%) reported employed full-time, and *N*=113 (17. 2%) were employed on a part-time basis.

Regarding income, the majority of women, *N*=253 (42%), reported a total family income ranging between $5,000 and $15,000 per year. The lowest numbers indicated that *N*=64 (10.6%) reported an income of less than $5,000 per year. Regarding marital status, *N*=406 (62.0%) of the women were involved as common law boy/girlfriend with the (ex) partner with whom they experienced IPV at the time, *N*=201 (30.7%) were legally separated or divorced while only *N*=48 (7.3%) were still married at the time reporting (Table 4.1).

Table 4.1 Demographics of participants *N*=670

	N (% of participants)
Age, in years mean ± SD	36.6 ± 11.4
17–25 years	119 (17.8)
26–35 years	224 (33.6)
36 years and over	324 (48.6)
Race/ Ethnicity *	
Aboriginal	331 (49.6)
Non-Aboriginal	337 (50.4)
Education Level	
Grade 11 or lower	285 (42.7)
Grade 12 or GED	139 (20.8)
Some postsecondary (technical/ trade school)	116 (17.4)
Postsecondary (university, Bachelor's degree or higher)	128 (19.2)
Employment	
Employed full-time	138 (21.0)
Employed part-time	113 (17.2)
Unemployed	405 (61.7)
Total Family Income	
Less than $5,000	64 (10.6)
$5,000– $15,000	253 (42.0)
$15,001-–$25,000	141 (23.4)
Above $25,000	145 (24.0)
Marital Status	
Married	48 (7.3)
Separated/ Divorced	201 (30.7)
Common law/ boyfriend/girlfriend/ (Ex)	406 (62.0)
Children	
Participants has children	605 (90.7)
Participant does not have children	62 (9.3)
Sources of Income–Social Assistance	
Yes	321 (48.4)
No	342 (51.6)
Sources of Income–Child Support	
Yes	105 (15.9)
No	557 (84.1)
Sources of Income–Spousal Support	
Yes	33 (5.0)
No	629 (95)

* The cultural background was coded into two categories (Aboriginal and non-Aboriginal). Aboriginals were defined as combination of First Nations, Indian, Métis, Inuit, Aboriginal, Non-status Indians, and mixture of any other identification like European, Caucasian or Visible Minority. Non-aboriginal cultural background was defined as combination(s) of European, Caucasian, white, Asians and other. See Appendix C.

Frequency counts were conducted in order to determine the prevalence of abuse in the lives of the participants. The history of abuse includes the length of time the participants experienced abuse with the current or most recent ex-partners, and whether (yes or no) they experienced abuse as children and/or adolescents.

Two hundred sixty-eight participants (40.7%) reported having experienced more than five years of intimate partner violence, while 222 (33.7%) participants experienced between 2–5 years and 168 (25.5%) fewer than 2 years of IPV. Two hundred seventy-two (40.9%) to 379 (57.0%) of the participants had experienced abuse of some form in their history. The highest percentage of abuse reported was physical abuse. See Table 4.2.

Table 4.2 History of abuse and type of abuse *N*=670

	N (% of participants)
Participant–Women	
Length of Time the Relationship was abusive, in years	
< 2 years	168 (25.5)
2–5 years	222 (33.7)
More than 5 years	268 (40.7)
Abused as Child/Adolescent–Physical Abuse	
Yes	379 (57.0)
No	286 (43.0)
Abused as Child/Adolescent–Sexual Abuse	
Yes	362 (54.7)
No	300 (45.3)
Abused as Child/Adolescent–Emotional Abuse	
Yes	441 (66.3)
No	224 (33.7)
Abused as Child/Adolescent–Witnessed Violence	
Yes	272 (40.9)
No	393 (59.1)
Abused as Child/Adolescent–Neglect	
Yes	272 (40.9)
No	393 (59.1)

Table 4.3 presents the percentage of participants who reported using each of the 28 emotion-focusing coping items. The results are listed in order from the strategies used by the most participants to those used by the fewest. Strategies used by more than 60% of participants will be defined as *high*-use strategies, and strategies less than 60% of participants will be defined as *low*-use strategies.

Table 4.3 shows that the strategies used by most of the participants are "cried to let your feelings out," "tried to figure out how to leave or stay out of the relationship," "thought things would get better," and "spent time with family/friends or kids." Strategies used least were "thought about trying to kill your partner," and "became sexually involved with someone else to feel comforted or protected."

Table 4.3 Percentage of participants who used each coping item [*N*=670]

Emotion-focused coping strategy	
Cried to let your feelings out	91.8
Tried to figure out how to leave or stay out of relationship	90.7
Thought that things would get better	89.5
Spent time with family/friends or kids	89.4
Distracted yourself from thinking about the abuse	88.6
Imagined yourself in a better time or place	87.1
Tried to figure out why your partner was abusive	86.8
Tried telling yourself that things weren't so bad	83.8
Became more independent	82.4
Prayed	82.1
Tried to see the good parts of your partner	81.1
Imagined yourself fighting back	80.4
Thought that changing yourself could change the problem	80.1
Thought that others are worse-off than you	77.1
Yelled and screamed to let off steam	74.7
Thought that your partner's abuse was the result of growing in a violent home	73.9
Taken it out on others when you felt angry/upset/depressed	66.3
Told yourself that you were not battered	64.8
Thought your partner would stop being violent if he/she stopped using alcohol or drugs	64.3
Made or tried to make new friends	63.0
Imagined your partner was dead	55.3
Exercised more to relieve stress and tension	54.4
Thought about trying to kill yourself	54.1
Used food to comfort yourself	53.8
Decided to not have any more sexual relationships with men	53.7
Thought your children weren't being affected your partner's violence or abuse	42.5
Thought about trying to kill your partner	33.8
Became sexually involved with someone else to feel comforted or protected	33.5

To evaluate the subjective outcomes of coping strategies, the participants rated the perceived helpfulness of each endorsed strategy from *not at all helpful* to *very helpful* (Bauman et al., 2008). Table 4.4 presents the mean perceived helpfulness scores for each coping item, from most to least helpful. Strategies rated between 0.01 and 1.99 are referred to as minimally helpful, strategies rated between 2.00 and 2.99 are referred to as moderately helpful, and strategies rated between 3.00 and 3.99 are referred to as extremely helpful.

Results show that participants considered the strategies of "became more independent," "prayed," "spent time with family/friends or kids," and "cried to let your feelings out" as extremely helpful strategies to cope with IPV.

Table 4.4 Average perceived helpfulness of emotion-focused coping strategies [*N*=670]

Emotion-focused coping strategy	Mean helpfulness
Became more independent	3.28
Prayed	3.11
Spent time with family/friends or kids	3.08
Cried to let your feelings out	3.01
Exercised more to relieve stress and tension	2.99
Imagined yourself in a better time or place	2.82
Tried to figure out how to leave or stay out of relationship	2.55
Made or tried to make new friends	2.36
Decided to not have any more sexual relationships	2.34
Imagined yourself fighting back	2.33
Yelled and screamed to let off steam	2.33
Distracted yourself from thinking about the abuse	2.26
Thought that others are worse-off than you	2.22
Thought that your partner's abuse was the result of growing up in a violent home	2.10
Imagined your partner was dead	1.93
Thought your partner would stop being violent if he/she stopped using alcohol/drugs	1.93
Tried telling yourself that things weren't so bad	1.80
Thought that things would get better after abuse	1.78
Tried to figure out why your partner was abusive	1.77
Thought that changing yourself could change the problem	1.73
Used food to comfort yourself	1.73
Thought about trying to kill your partner	1.60
Tried to see the good parts of your partner	1.56
Became sexually involved with someone else to feel comforted/protected	1.44
Thought that your children weren't being affected by your partner's violence	1.44
Told yourself that you were not battered	1.34
Thought about trying to kill yourself	0.91
Taken it out on others when you felt angry/upset/depressed	0.80

Strategies considered most helpful were "became more independent," "prayed," "spent time with family/friends or kids," and "cried to let your feelings out."

4.2 Inferential Analysis

Hypothesis one states that there is no relationship between exposure to violence and symptoms of posttraumatic stress. A bivariate correlational analysis using the Pearson product–moment correlation coefficient was conducted to evaluate the relationship between the Posttraumatic Stress Checklist (independent variable) and Composite Abuse Scale (dependent variable). There was a correlation between the two variables (N=505*)* (r=0.281, p=0.0001).

Hypothesis two states that there is no relationship between exposure to IPV and use of emotion-focused coping strategies. A bivariate correlational analysis using the Pearson product–moment correlation coefficient was conducted to evaluate the relationship between the Emotion-Focused Coping Strategy (independent variable) and Composite Abuse Scale (dependent variable). There was a correlation between the two variables *(*N=505*)* (r=0.110, p=0.013).

Hypothesis three states that there is no relationship between the use of emotion-focused coping strategy and an increase in self-reported symptoms of posttraumatic stress. A bivariate correlational analysis using the Pearson product–moment correlation coefficient was conducted to evaluate the relationship between the Posttraumatic Stress Checklist (independent variable) and Emotion-Focused Coping Strategy (dependent variable). There was a correlation between the two variables *(*N=495*)* (r=0.090, p=0.046). See Table 4.5.1.

Table 4.5.1 Correlation analysis–Univariate (one variable at a time) between Posttraumatic Stress Disorder Checklist, Composite Abuse Scale, and Emotion-Focused Coping Strategy

Independent Variable	Dependent Variable	Pearson Correlation Coefficient	*P* value (two sided)	*N*
PCL	Composite Abuse Scale	0.281	<0.0001***	505
EFCS	Composite Abuse Scale	0.110	0.013**	505
PCL	EFCS	0.090	0.046*	495

Correlation is significant at the * $p < .05$ and ** $p < .01$ and *** $p < .001$ levels.

A Pearson product–moment correlation coefficient was computed to assess the relationship between emotion-focused coping strategies as measured in the EFCS (variable 1) and types of abuse as measured in the Composite Abuse Scale subscales (variables 2). There was a correlation between the variables EFCS and Severe Combined Abuse Scale *(r*=0.100*, p*=0.019*)*, EFCS and Emotional Abuse Scale *(r*=0.113*, p*=0.007*)*, EFCS and Physical Abuse Scale *(r*=0.066*, p*=0.115*)* and EFCS and Harassment Abuse Scale *(r*=0.053*, p*=0.223*)*.

See Table 4.5.2.

Table 4.5.2 Correlation analysis–Univariate (one variable at a time) between Composite Abuse Scale Subscales and Emotion-Focused Coping Strategy

Independent Variable	Dependent Variable CAS Subscales	Pearson Correlation Coefficient	*P* value (two sided)	*N*
EFCS	Severe Combined Abuse Scale	0.100	0.019*	550
EFCS	Emotional Abuse Scale	0.113	0.007**	561
EFCS	Physical Abuse Scale	0.066	0.115	564
EFCS	Harassment Abuse Scale	0.053	0.223	535

Correlation is significant at the * $p < .05$ and ** $p < .01$ levels.

A Pearson product–moment correlation coefficient was computed to assess the relationship between the types of posttraumatic stress symptoms as measured in the PCL subscales and emotion-focused coping strategies as measured in the EFCS. There was a correlation between both variables. See Table 4.5.3.

Table 4.5.3 Correlation analysis–Univariate (one variable at a time) between Posttraumatic Stress Disorder Checklist Subscales and Emotion-Focused Coping Strategy

Independent Variable PCL Subscales	Dependent Variable Coefficient	Pearson Correlation (two sided)	*P* value	*N*
Intrusion [a]	EFCS	0.065	0.143	505
Avoidance [a]	EFCS	0.062	0.161	507
Numbing [a]	EFCS	0.083	0.114	500
Arousal [a]	EFCS	0.085	0.058	504

Correlation is significant at the * $p < .05$, ** $p < .01$, *** $p < .001$

A Pearson product–moment correlation coefficient was computed to assess the relationship between types of posttraumatic stress symptoms as measured in the PCL subscales and types of abuse as measured in the Composite Abuse Scale subscales. There was a correlation between all the variables of the PCL subscales and CAS subscales. See Table 4.5.4.

Table 4.5.4 Correlation analysis–Univariate (one variable at a time) between Posttraumatic Stress Disorder Checklist Subscales and Composite Abuse Scale Subscales

Independent Variable PCL Subscales	Dependent Variable CAS Subscales	Pearson Correlation Coefficient	P value (two sided)	*N*
Intrusion [a]	Severe Combined Abuse Scale [b]	0.331	<0.0001***	559
Intrusion [a]	Emotional Abuse Scale [b]	0.288	<0.0001***	572
Intrusion [a]	Physical Abuse Scale [b]	0.214	<0.0001***	571
Intrusion [a]	Harassment Abuse Scale [b]	0.201	<0.0001***	549
Avoidance [a]	Severe Combined Abuse Scale	0.215	<0.0001***	562
Avoidance [a]	Emotional Abuse Scale	0.158	<0.0001***	574
Avoidance [a]	Physical Abuse Scale	0.161	<0.0001***	575
Avoidance [a]	Harassments Abuse Scale	0.179	<0.0001***	551
Numbing [a]	Severe Combined Abuse Scale	0.228	<0.0001***	558
Numbing [a]	Emotional Abuse Scale	0.131	0.002**	570
Numbing [a]	Physical Abuse Scale	0.178	<0.0001***	569
Numbing [a]	Harassment Abuse Scale	0.105	0.014*	545
Arousal [a]	Severe Combined Abuse Scale	0.247	<0.0001***	562
Arousal [a]	Emotional Abuse Scale	0.197	<0.0001***	573
Arousal [a]	Physical Abuse Scale	0.216	<0.0001***	574
Arousal [a]	Harassment Abuse Scale	0.159	<0.0001***	549

Correlation is significant at the * $p < .05$ and ** $p < .01$ and *** $p < .001$ levels.
[a] Subscales of the PCL. [b] Subscales of the CAS.
* $p < .05$. ** $p < .01$. *** $p < .001$

Note. The dataset contained 2 Waves of the CAS, 1 Wave for EFCS, and 1 Wave for the PCL. The correlational analysis used the scores from CAS Wave 1 to run the analysis. This was due to a t-test showing that individual items each have *N*=580 missing, highlighting that the scores on CAS Wave 1 and CAS Wave 2 were very different. Scores are much lower in CAS Wave 2, i.e.,

participants' scores on CAS were greatly reduced. This finding is highly significant, because it means that participants answered differently in Wave 1 and Wave 2. The time lapse between each wave may have mitigated the memory of the abuse(s), and/or some may have been ready to move away from being abused by their partners.

4.3 Correlational Results

Hypothesis 1 stated: There is no relationship between exposure to violence as measured in the Composite Abuse Scale and symptoms of posttraumatic stress as measured in the Posttraumatic Stress Checklist.

Hypothesis 1 was rejected. Correlation analysis showed a significant positive correlation of 0.281 ($p < .0001$) (Table 4.5.1), representing a medium-sized effect.

Subscales. Both the CAS and the PSTD contain four subscales. Thus, 16 correlations were measured to test the relationships between subscales. Results are shown in Table 8. All correlations were significant. Most were highly significant, at $p < .0001$. The correlation between emotional abuse and numbing was significant at $p < .01$, and the correlation between harassment and numbing was significant at $p < .05$.

Hypothesis 2 stated: There is no relationship between exposure to intimate partner violence as measured in the Composite Abuse Scale and use of emotion-focused coping strategies as measured in Emotion-Focused Coping Strategies.

Hypothesis 2 was rejected. Analysis showed a significant positive correlation of 0.110 ($p = .013$), representing a small effect size. See Table 4.5.1.

4.3.1 Subscales of CAS and EFCS Correlation

Correlations were measured to test the relationships between the four CAS subscales and the EFCS. There were significant correlations for the EFCS and severe combined abuse scale ($p < .019$) and between EFCS and emotional abuse scale ($p < .007$). There were no significant

findings of correlation between EFCS and Physical Abuse Subscale and EFCS and Harassment Abuse Subscale. See Table 4.5.2.

Hypothesis 3 stated: There is no relationship between use of emotion-focused coping strategies as measured in the Emotion-Focused Coping Strategies and symptoms of posttraumatic stress as measured in the PCL.

Hypothesis 3 was rejected. There is a correlation between higher use of emotion-focused coping strategies (EFCS) and more self-reported symptoms of PTSD. Analysis showed a significant positive correlation of 0.090 (p = .046) significant at p <. 05 levels. See Table 4.5.1.

4.3.2 Subscales of PCL and EFCS

There was no correlation between PCL subscales and EFCS.

CHAPTER 5: DISCUSSION

This chapter provides a summary of the present study and a discussion of its findings and limitations. Recommendations for further research on IPV and mental health and implications for future practice and intervention are also discussed.

This study explored the relationship between exposure to IPV and symptoms of posttraumatic stress; of exposure to IPV and use of emotion-focused coping; and use of emotion-focused coping and posttraumatic stress. Results of correlation analysis revealed significant positive relationships between exposure to IPV and symptoms of posttraumatic stress, exposure to IPV and use of emotion-focused coping, and use of emotion-focused coping and symptoms of posttraumatic stress. The results of this study extend current research in the area of emotion-focused coping and posttraumatic stress in women who have been exposed to IPV.

5.1 Summary of the Findings

This exploratory study was prompted by the limited amount of research on the ways women who have experienced IPV cope and how their experiences impact their mental health. In an effort to address gaps in the research in this area, correlational analysis was used to explore the relationship between emotion-focused coping and posttraumatic stress. Three self-report measures were used to gather data from women who were abused by their intimate partners: the Composite Abuse Scale (CAS), the Emotion-Focused Coping Strategy (EFCS) questionnaire, and the Posttraumatic Stress Checklist (PCL).

The first hypothesis sought to explore the relationship between women's exposure to IPV and symptoms of posttraumatic stress by stating the null hypothesis, that there was no relationship between the two variables. Data analysis confirmed a significant correlation between exposure to IPV and symptoms of posttraumatic stress. This finding is consistent with the

general body of research, such as Taft et al.'s (2007a) study of IPV and PTSD. Taft et al. (2007a) suggested not only that there is a correlation between these variables, but also that women's exposure to IPV is predictive of the development of posttraumatic stress. They suggest that one of the most prevalent mental health sequelae of intimate partner violence is posttraumatic stress, which places women at risk for developing posttraumatic stress disorder.

Despite the abundance of research on the various psychosocial and mental health outcomes of IPV and the initiatives taken to address them, IPV continues to represent a serious national and international public health problem. Robertiello (2006) suggested that the mental health impact of IPV could be more debilitating than physical injuries. He reported that symptoms of posttraumatic stress frequently go undetected, and therefore unaddressed, by medical staff, thus placing the women who have experienced IPV at further risk of mental and emotional disorders. Unidentified and unaddressed mental health concerns can place the women at risk of further abuse, which may ultimately have lethal outcomes, such as suicide by the victims or homicide by the perpetrators of the violence.

The IPV experienced by battered women is not uniform. Instead, women often experience a constellation of physical violence, sexual and emotional abuse, and harassment. The severity of each type of violence also varies and the types of violence are often not evident in isolation. It is important to examine the correlation between complex profiles of violence experienced by women and the associated mental health outcomes (Dutton et al., 2005). Women's life circumstances, family histories, personalities, temperaments, support systems, and cognitive abilities are some of the contributing factors that may influence women's experience with IPV. The complexity of women's experiences with IPV suggests the need to consider the multi-dimensional ways that they have learned to cope with abuse in their intimate partnerships

(Dutton, 2009). When faced with the challenges of IPV, women will engage in multiple coping strategies, often practiced simultaneously, until the stress is reduced (Lilly & Graham-Bermann, 2010).

Literature on coping with IPV generally recognizes two broad categories of coping, namely emotion-focused coping (also known as disengagement coping) and problem-focus coping (also known as engagement coping). Emotion-focused coping has been used in situations where the women may not have had any control over the abuse that they experienced. This way of coping encourages a focus on regulating emotions (Lilly & Graham-Bermann, 2010) to help the women survive their experiences, or simply avoid negative outcomes of traumatic distress. Problem-focused coping may take place when and if there is a perceived sense of control, such as the ability to seek outside assistance through social services or women's shelters. The individual woman and the unique circumstances of her situation ultimately determines which form of coping she will or has used at a given point in time.

Canady and Babcock (2009) suggested that there are many context-dependent variables that can affect the use and effectiveness of the coping strategies employed to maintain or regain equilibrium after women's experience of IPV. Mechanic, Weaver, and Resick (2000) identified context-dependent variables they define as "ecological stressors" such as poverty, lack of material and social resources, parenting stress, and other stressors secondary to partner abuse or separation from an abusive relationship. Further to this, Dutton (2009) proposed a number of factors that may impact the ability of women to cope with abuse and to either trigger or prevent the onset of symptoms of posttraumatic stress. These factors include poor self-esteem, depression, hopelessness, and dysphoria, which are correlated with posttraumatic stress or increased likelihood of a PTSD diagnosis. Another factor that affects the development of

posttraumatic symptoms is the way in which the woman copes with the violence (Lilly & Graham-Bermann, 2010). The current study explored one dimension of coping in the aftermath of IPV, namely emotion-focused coping, and its relationship to symptoms of posttraumatic stress.

The second hypothesis, stated in the null, was that there is no relationship between women's exposure to IPV and their use of emotion-focused coping strategies. This hypothesis was rejected. The greater women's exposure to IPV, the more likely they were to report using emotion-focused coping. This finding extends research on women's use of emotion-focused coping strategies in the presence and aftermath of IPV. This finding may be attributable to the variety of ways the women had to cope in order to survive and manage their lives at the time the abuse was occurring. The women in this study may have been reluctant or unable to leave their abusive relationships and therefore may have had to engage in managing their reactions and complicated emotions resulting from the violence they were facing. Lilly and Graham-Bermann (2010) suggested that as violence increases, however, women may engage in different coping strategies to preserve their safety and to deal with their subsequent distress. Once sufficient resources required to leave the abusive relationship have been summoned, a woman may be able to take more active steps to leave.

The third hypothesis, again stated in the null, was that there was no relationship between emotion-focused coping strategies and symptoms of posttraumatic stress among women who have experienced IPV. This hypothesis was also rejected. There was a significant positive correlation between use of emotion-focused coping and symptoms of PTDS. These findings are consistent with Lilly and Graham-Bermann's (2010), which found that emotion-focused coping moderated the development of symptoms of PTSD in a population of 97 women recruited from

domestic violent shelters in southeastern and central Michigan. They found that the use of emotion-focused coping strategies increased with increased exposure to violence and an escalation of PTSD symptoms. This could imply that if the women did not engage in emotion-focused strategies, they may have developed even more symptoms of PTSD. Research that sheds light on optimal coping strategies for women who have experienced IPV is urgently needed to inform intervention, prevention, and advocacy efforts required to mitigate the onset of PTSD.

5.2 Correlation Between Different Types of Abuse and Symptoms of Posttraumatic Stress

The "constellation" of violence and abusive behaviours experienced by women may trigger the onset of different symptoms of posttraumatic stress and may also influence the types of coping strategies women employ. The CAS and the PCL have embedded subscales to measure different types of abuse and posttraumatic symptoms. Information from the correlation of the subscales may reveal subtle differences between different types of abuse and their mental health outcomes. The CAS subscales measure the different types and levels of violence that women experience in their intimate relationships, including emotional abuse, physical abuse, harassment, and severe combined abuse. The PCL subscales measure the different types or manifestations of symptoms of posttraumatic stress that are typically seen or experienced in clusters. The clusters of posttraumatic stress symptoms include avoidance, numbing, arousal, and intrusion of thoughts or memories of the traumatic experience(s).

This study confirmed an *overall* correlation between the IPV and symptoms of posttraumatic stress. However, when the results on subscales were compared, a slight variance or higher significance between emotional abuse (CAS subscale), harassment (CAS subscale) and numbing (PCL subscale) was found. Specifically, women who had experienced emotional abuse and harassment reported higher rates of numbing symptoms. For women having experienced

IPV, symptoms of numbing may have included feeling distant or cut off from loved ones, feeling emotionally numb or unable to love, or feeling as though their futures will be cut short.

Research on emotional abuse and harassment is beginning to receive increased attention. Research also shows that emotional abuse and harassment have been associated with worse mental health outcomes as manifested by increased rates of depression and PTSD (Dutton et al., 2005). In their study of 114 American women who were stalked by their intimate partners, Mechanic et al. (2000) suggested that the constructs of emotional abuse and harassment can be understood as "coercive control tactics." Their findings confirm that these women experienced high levels of fear that placed them at greater risk of PTSD, as well as functional impairment in employment, health status, and quality of life.

Dutton (2005) further suggested that women who have experienced more physical violence tend to use more active or problem-focused strategies to cope with the violence, whereas emotional abuse and harassment are more closely associated with women's use of emotion-focused strategies, which increase their vulnerability to experiencing symptoms of posttraumatic stress.

5.3 Correlation Between use of Emotion-Focused Coping and Different Types of Abuse

When analysis was conducted to explore the relationship between women's experience of IPV and their use of emotion-focused coping strategies, the results indicated a split in significance between two of the CAS subscales. The more the women experienced emotional and severe-combined abuse, the more they reported using emotion-focused coping strategies, while reports of women who experienced physical abuse and harassment showed no correlation with emotion-focused coping. These findings are consistent with the notion that physical forms of abuse may lead to more problem-focused, or engagement, forms of coping (Taft et al., 2007b),

while severe-combined abuse and emotional abuse may result in more symptoms of posttraumatic stress in part because of an increase in emotional-focused coping. This may be attributed to the "visibility" or "tangibility" of physical abuse and harassment, which can be addressed more readily by support systems. Visibility and tangibility become the principal grounds for first response protective interventions. The women who participated in this study were recruited through shelters and support agencies. Therefore, these women may have had greater access to a supportive and responsive social network that helped them cope with the violence in a more timely manner than those with less visible or physical manifestations of IPV, such as emotional abuse and harassment.

Another possible explanation for the discrepancy in significance between the whole CAS-EFCS output and CAS subscales-EFCS output may be the numbers of participants who completed the self-report measures. When the data of the whole CAS were entered, the number of participants was higher. When the CAS subscales were analyzed separately, the number of participants decreased. The difference in number of respondents may have contributed to the difference in correlation output.

5.4 Demographic Findings

The results of this study indicated that the largest percentage (48.6%) of the women were 36 years of age or older. However, the *combined* sum of women 17 to 25 years of age (17.8%) and 26 to 35 years of age (33.6%) was 51.4%, a 2.5% difference between the older population and those under 36 years of age. This confirms some studies showing a higher rate of IPV among the younger population. Rennison and Rand's (2003) study of data from the National Crime Victimization Survey (NCVS 1993–2001) found that IPV rates and the ages of women who had experienced IPV were inversely related: Younger women experienced IPV at significantly higher

rates than mid-age women, and mid-age women experienced IPV at significantly greater rates than mature women. The age categories they presented were 12 to 24 as young, 25 to 54 as mid-age, and 55 and older as mature. Another cross-sectional study among a sample of more than 14,000 women on the impact of IPV among women in Victoria, Australia, found that the highest rate of IPV was among women 45 years and older (Vos, Astbury, Piers, Magnus, Heenan, Stanley, Walker, & Webster, 2006). Taken as a singular population, the larger percentage of women who experienced IPV and who were included in this study were 36 and older.

The current study explored the representation of Aboriginal versus non-Aboriginal women who had experienced IPV. In this study, 49.6% of the women self-identified as Aboriginal, compared to 50.4 % who self-identified as non-Aboriginal. Generally, a difference of 0.8% is not considered significant. However, it is noteworthy that the difference leans higher towards the non-Aboriginal population. Brownridge (2008) conducted a comparative study which examined Aboriginal women's elevated risk for violent victimization relative to non-Aboriginal women using two large-scale representative surveys (Canadian National Violence Against Women Survey and two years of the Canadian General Social Survey). His findings were varied. He found that Aboriginal and non-Aboriginal women experienced fairly similar rates of violence. Each of these surveys indicated fewer differences between Aboriginal and non-Aboriginal women in the 2004 survey than in the 1999 survey. To explain these differences, Brownridge suggested that there is a reduction in patriarchal domineering behavior by partners of Aboriginal women. An alternative explanation is that the results could be due to random fluctuations in samples.

The Public Health Agency of Canada (2008) suggested that Aboriginal women who have experienced IPV often report violence in their family of origin, low self-esteem, histories of

substance abuse (among both the women and the men who perpetrate the violence), fetal alcohol syndrome, low levels of education, poverty, and being young of age compared to non-Aboriginal women.

The majority of women in this study reported education levels of Grade 11 or lower, were unemployed, had a total family annual income of $5,000 to $15,000, and virtually all of them had children. There is a possibility that inadequate resources for education and income may have placed women at further risk of stress. These findings are consistent with the results of Ergin, Bayram, Alper, Sleimoglu, and Bilgel's (2005) study that explored the prevalence, type, frequency, and causes of IPV among approximately 1,000 Turkish women in socioeconomically developed metropolitan settings. They found that IPV was significantly associated with education levels in that illiterate women reported 2.6 times more abuse than university-trained or more educated women. The factors that put women at increased risk for violence could place them at further risk of experiencing symptoms of posttraumatic stress. It is important to note, however, that women of all ages, levels of education, and income are vulnerable to experiencing violence at the hands of their male partners.

The current study assessed the prevalence of the use of emotion-focused strategies among women who had experienced IPV. The majority of these strategies were utilized by more than half of the participants in the study, indicating that these women used a wide range of emotion-focused strategies to cope with their experience of IPV. Emotion-focused coping strategies that involved aspects of self-harm, aggressive behavior, minimizing or denying the IPV, and making meaning out the experience of IPV were perceived as the least helpful. Strategies that were perceived as most helpful included expressing emotions (such as crying), problem solving, facilitating empowerment (such as becoming more independent), seeking social support,

engaging in distractions, increasing independence, and taking care of one's self. Overall, strategies that reflected increased independence, spirituality, and seeking social support ranked very high in perceived helpfulness in dealing with the IPV.

The strategy used most often by the women who participated in this study was crying to let their feelings out, a form of emotional expression. In a Swedish study on crying involving 14 family members in palliative care, Ryde, Straus, and Friedrichsen (2008) found that crying facilitated well-being and served as an escape, providing solitude and breathing space. They suggested that crying is an adaptive response that promotes the integrity of the person where the general life goal could be both mastery and survival. Using the lens of adaptation, they viewed crying, as a coping response to changes in the environment, which regulated both the physiological and psychosocial needs of the individual.

In their study examining the connections between individual affective characteristics and mood among 97 women in the Netherlands, Bylsma, Croon, Vingerhoets, and Rottenberg (2011) found a strong correlation between crying and emotion regulation, including anxiety, substance abuse, depression, and other variables characterized by affective instability. Their findings suggested that crying induced a more positive mood and that reduced crying experiences were associated with more symptoms of depression. In another international study examining the cathartic effects of crying on 2,181 men and 2,915 women across 35 countries, Bylsma et al. (2008) found a positive correlation between crying and cathartic experience. They define the cathartic experience of crying as a method of releasing or discharging tension that may be built up as a result of inhibited feelings or emotion that cannot be expressed effectively in situations where an individual cannot properly cope. Given these findings, it is noteworthy to learn that expression of emotion through crying could have beneficial outcomes for women exposed to IPV

and thus contribute to a woman's capacity to survive the experience. Although crying has not been defined as an engagement or disengagement strategy of coping, there are positive implications of its use to help women cope with the stresses of IPV.

Although emotional expression may have been a helpful way of coping with IPV for the women in this study, the findings indicated the presence of posttraumatic stress nonetheless. Coping is only one variable that may influence or mitigate the development of symptoms of posttraumatic stress. For this group of women, the expression of emotion as a coping strategy may have worked best in conjunction with interventions that provided further support.

The strategies reported as being used the *least* by the women in this study were "became sexually involved with someone else to feel comforted or protected" and "thoughts about trying to kill your partner." This is an encouraging finding because these are strategies that would be discouraged in interventions as they are commonly viewed to be problematic or dysfunctional forms of coping.

These findings take on increased importance in our learning about how women who have experienced IPV engage in strategies available to them at the time to cope with the stress of violence and abuse. They also shed light on understanding the contexts of women's lives. There may be contextual factors such as financial resources, education, support systems inclusive of friends, family or spiritual resources, family of origin experience with IPV, and availability of safe houses and counselling services that impact how a woman copes with violence.

At least half of the women who participated in this study had experienced some form of abuse as a child or adolescent. The long-term effects of childhood abuse have been found to have potentially debilitating effects on mental health in adulthood. This study revealed that the majority of women had been in the abusive relationships for five or more years. Carlson et al.

(2002) suggested that living with violence for extended periods of time from childhood/adolescence through adulthood could lead to a wide range of mental health sequelae, including posttraumatic stress, anxiety, depression, cognitive distortions, interpersonal problems, low self-esteem, and self-destructive behaviours such as suicide attempts, substance abuse, and revictimization, to name a few. The joint impact on mental health for women who have experienced IPV and face additional limitations due to lack of resources or lack of support could be deleterious, furthering a sense of having little to no control of their own lives and/or those of their children. Taft et al. (2007a) postulated that based on the general coping literature suggesting the importance of matching coping behaviours to the "controllability" of the situation, research should examine predictors of different forms of coping to better understand factors that may lead to well being for women who have experienced violence in their intimate partnerships.

5.5 Coping with IPV and Mental Health

Lilly and Graham-Bermann (2010) noted that "Perhaps the most striking feature of the literature on survivors of IPV is the extent to which women use a variety of coping strategies in the face of horrific conditions" (p. 606). The women in the current study utilized a variety of emotion-focused coping strategies. As noted, it appears that a higher percentage of coping strategies utilized, such as "cried to let your feelings out," "became more independent," and "praying" may have reduced the risk of having more symptoms of posttraumatic stress. Coping strategies such as "used food to comfort yourself," "thought about trying to kill your partner," and "became sexually involved with some else to feel comforted or protected" were used less frequently, which may have helped to further reduce the symptoms of posttraumatic stress. Mental health care providers would, most likely, encourage women who have experienced IPV

to make use of strategies that might reduce the symptoms of posttraumatic stress, such as praying more and seeking more support from friends, family, and support agencies.

Significant positive associations were found between praying (spiritual or religious activity) and decreased risk of negative mental health outcomes, including suicide attempts, as a result of IPV. Studies have found that higher levels of religious coping and religious activities such as praying were highly correlated with lower levels of hopelessness and other psychosocial difficulties (Meadows, Kaslow, Thompson, & Jurkovic, 2005; Arnette, Mascaro, Santana, Davis, & Kaslow, 2007). In their study on spirituality and healing with patients dealing with cancer, Torosian and Biddle (2005) concluded that improved recovery from illness and surgery, reduction of stress and anxiety, relief of pain, and improved coping are associated with spirituality that incorporates praying, faith, and religion. Praying was one of the coping strategies used most by the women in this study, implying that the women using this strategy may have also decreased their symptoms of posttraumatic stress by finding comfort and strength in this activity.

Other emotion-focused copings strategies used most and found most helpful were directed more towards trying to figure out whether to leave or stay out of the abusive relationship and becoming more independent. The current study found that 40.7% of the women were in the abusive relationship for five or more years, 33.7% between 2 and 5 years, and 25.5% for fewer than two years. Research on the length of time women are involved in abusive relationships and coping strategies has not produced much information. The findings of the current study suggest that the emotion-focused coping strategies might have been used by this sample of women until it became possible for them to leave the abusive relationship. Coping by trying to find ways of distancing oneself from the abuse would be considered as healthy and functional, and these

strategies would be considered protective of mental health encouraged by mental health care providers.

In their study of IPV and mental health outcomes among a sample of 61 women utilizing shelter services in the United States, Cobb, Tedeschi, Calhoun, and Cann (2006) discovered that the abuse and the struggle to survive psychologically may lead to some important changes that are regarded by those who experience them as positive in nature. In women's efforts to leave the abusive relationship, thinking and attempting to become independent contributed greatly to posttraumatic growth, a phenomenon of positive personal change following devastating events such as IPV.

Spending time with family/friends or children is another strategy found to be helpful in coping with symptoms of posttraumatic stress. Taft et al. (2007b) suggested that a higher level of engagement with personal and environmental social support resources moderates the relationship between coping and emotional well-being. Kocot and Goodman (2003) found that social support does not guarantee mental health. They found a positive correlation between coping mechanisms involving support systems and high levels of depression symptoms. Their findings suggest that the women may have received poor advice and input from their support systems, which may have considered the women to be the cause of the violence or may have advised the women to stay in the abusive relationship. These factors may have led to further hardships for the women that further taxed their mental health.

Coping strategies can be protective or risk engendering, and sometimes the same strategy may serve both functions to ensure survival. The use of various coping strategies is often necessary for women to survive the violence in the short term. A woman may have to "put up with the beatings" until she can find a way out of the abusive relationship. However, in the

longer term, any strategies used for coping that make it more likely that a woman will remain in the abusive relationship could have potentially harmful consequences because she risks facing more violence and abuse.

Lilly and Graham-Bermann (2010) found that more active forms of coping such as confronting the perpetrator of the violence or trying to leave the abusive relationship, increased the frequency of violence for some women. This dynamic might contribute to some women's reluctance or inability to leave an abusive relationship, and might instead lead them to manage their complicated emotions in order to survive. As violence increases, women may engage in more internal coping strategies to preserve their safety and the safety of their children. Once sufficient resources, for example, social or familial, legal, or financial have been summoned to ensure the women's safety and that of their children, the women may begin to take more active steps to leave the relationship.

The implications of the findings of this study are consistent with current literature on IPV, coping, and posttraumatic stress. Dutton (2009) and Sutherland, Byebee, and Sullivan (2002) confirmed that it is now well recognized through cross-sectional and longitudinal investigations of women from domestic violence shelter programs, emergency rooms, and primary health clinic settings that it is typical to find a history of IPV in women's childhood or adulthood. They confirm that IPV places women at risk for physical and psychological illness, and more specifically PTSD-related problems. Lilly and Graham-Bermann (2010) found that women with previous and/or long-standing histories of IPV employ emotion-focused coping strategies and also report higher rates of posttraumatic symptoms regardless of the extent of their exposure to violence. The findings in this study suggest emotion-focused coping strategies uniquely factor into the experience of IPV and subsequent mental health outcomes for women.

5.6 Limitations

There are five key limitations of the current study:

1) The participants' reporting of their memories of the violence and their coping strategies may have been altered with the passage of time.
2) The sample of participants was recruited mainly through service provider agencies, and the women may have already received support, possibly limiting generalization about outcomes.
3) Missing responses in the data set may have impacted the statistical outcomes.
4) The quantitative design of this study was limited to quantitative responses from the women. It did not allow for the women's voices to be expressed or heard.
5) Emotion-focused coping strategies are only one way in which women cope with IPV.

5.6.1 Generalization

Women's coping strategies are unique and context specific, making the development of a single measure to identify how women cope with IPV very complex. Some theories suggest that differences in coping style are intrinsically tied to ecological contexts and personality dispositions. Due to the uniqueness of each woman's situation, making generalizations about how all women cope with IPV is problematic. The length of time a woman has been exposed to IPV, the types of abuse she has experienced, and the resources available to her, to name a few possibilities, may determine how she has coped. Personality characteristics could potentially predispose women to cope in their own unique way when confronted with adversity. For instance, some women may be predisposed to passive responses to life circumstances while others may engage more active coping response.

Bauman et al. (2008) suggested that IPV is a dynamic process that happens over time. Violence manifested at the early stages of the relationship may involve neglect or verbal abuse and could escalate over time into physical or sexual abuse. Thus, a woman's approach to coping

with the violence could change accordingly. As the interpersonal dynamics of her relationship with her partner changes, so will her responses to her relationship. Thus, coping strategies cannot be viewed as "static" responses. Carver et al. (1989) stated that a given coping strategy, such as emotion-focused coping, should not be viewed as intrinsically maladaptive; it may become dysfunctional if it is relied on for long periods when other strategies would be more useful.

Women who have been exposed to IPV will utilize familiar and accessible strategies in the absence of available and workable strategies and resources. Their use of coping strategies may also be limited and restricted by a partners' use of control tactics that restrict access to supportive resources such as money and social support networks. The coping strategies reported by the women in this study were limited to only one measure of coping. The women may have used other forms of coping that are not measured by the EFCS.

Lenore Walker (1980) asserts that not all women who have experienced IPV will develop symptoms of posttraumatic stress. Even when they do they may not need more intervention than participation in a support group with others in similar circumstances. She argues, however, that many women continue to experience IPV even after they separate from and divorce the abusive husband. This is particularly frequent for women who are forced into involuntary joint-custody arrangements where they must stay in the same neighborhood and have constant contact with the abuser. She claims that the symptoms of posttraumatic stress will not be reduced if there is still danger of being harmed; no matter how much therapy the woman receives.

Another limitation is that the women's memory of the violence may have changed over time. The time lapse between the direct experience of IPV and data collection varied according to each participant's circumstances. The use of retrospective reports requires caution when

interpreting findings because encoding and memory alterations have been linked to the presence of trauma symptoms (Taft et al., 2007b).

Another limitation is the use of a sample of participants recruited through service provider agencies in Saskatchewan, Manitoba, and Alberta. There is a possibility that the participants in this study had been involved with interventions that facilitated different levels and types of coping since they were recruited on the basis of their help-seeking behavior. This may have affected how women who have experienced IPV perceive and report their coping strategies and their current experience of posttraumatic stress. It is difficult to generalize the results of this study to apply to all women who have experienced IPV. There is a large population of women who have little to no access to resources to deal with IPV. Diverse cultural, ethnic, and contextual circumstances would have to be considered when generalizing the results of this study.

Voluntary participation and the possibility of not answering questions was a limitation that may have impacted the "missing response" output of the analysis. This implies that not all of the questions were required to be answered all of the time by the participants.

Finally, the quantitative design of this study and the questionnaires did not allow women to speak for themselves about the ways in which their personal experiences shaped their coping strategies (Kocot & Goodman, 2003). Qualitative research could allow for the process of inquiry to occur with open-ended questions, thus enhancing the possibilities of women being able to express themselves more fully as they use their own words to describe their experiences with IPV.

5.6.2 Limitations with the Dataset and the Coping Measure

The limitations of the dataset created complexities in scoring and analysis. Generally, when there are waves in a dataset, it is necessary to perform comparative t-tests between the waves to look for any differences before proceeding to the next level of analysis. There were two waves for the CAS and only one wave for the EFCS and the PTSD measures. A preliminary comparison t-test was conducted for the CAS between the two waves.

There were significant differences in the number of people who responded to the CAS and different responses between the two waves. The decision was made to use the CAS with the most respondents in the correlational analysis.

There were limited references for the coping measure used in this study. The construct validity and reliability of the Emotion-Focused Coping Strategy questionnaire was limited to the one journal article by Bauman et al. (2008) that documented the development of the questionnaire. This measure was originally used to assess emotion-focused coping strategies in relation to mental health related outcomes, specifically posttraumatic stress.

5.7 Implications for Future Research

Robertiello (2006) suggested that even though there is a plethora of data on IPV, there are few studies on its mental health effects. Yet, the psychological impact of IPV can be more debilitating than physical injuries. From their meta-analysis of more than 40 studies of mental health effects of IPV among women in clinical settings, Carlson et al. (2002) suggested that the considerable impact of IPV on mental health leads to elevated levels of depression, suicide attempts, anxiety, and posttraumatic stress disorder. Although coping and recovery from posttraumatic stress symptoms due to IPV is crucial, Taft et al. (2007a) suggested there has been

a notable dearth of empirical investigations examining the relationship between different forms of coping and mental health outcomes among this population.

Women who have survived violence and lived to tell their story have demonstrated resilience and strength. Resilience is defined as the ability to endure and recover from crises and traumatic life experiences (Holliman, 2006). Therefore, research on the topics of IPV, coping, and posttraumatic stress could benefit from a strength-based or resiliency perspective. With deepened understanding of the ways women cope with IPV, researchers and practitioners may be better equipped to develop resources that will foster hope and empowerment for women.

The results of the current study have several implications for future research utilizing the Healing Journey project data that could inform practice and intervention. As a longitudinal study spanning a five years, the Healing Journey project has accumulated a wealth of information about women's experience and the effects of IPV. These data are an invaluable source of information relevant to women in Canada and perhaps throughout the world. Intimate partner violence is well recognized as a current global concern. This rich body of data could enhance current literature and inform effective interventions and policy and legislation for women and children who have experienced IPV.

The data from the Healing Journey project contain a vast amount of quantitative and qualitative information. Further research incorporating more correlational and predictive studies of causes and outcomes resulting from violence could be undertaken. Analysis of the qualitative interviews that were conducted with women exposed to IPV could provide a broader and deeper understanding of the subject. Additional longitudinal examinations attempting to further understand the complexities of coping are needed to inform the practices of medical, psychological, judicial, and human service providers who work with women affected by IPV.

5.7.1 Implications for Current Practice and Interventions

The results of this study have implications for first response support services, including shelters, mental health and medical practitioners, and the judicial system. With more knowledge on how different women cope with IPV, the support systems can facilitate more effective prevention of the potentially debilitating mental health consequences of IPV. More specifically, women who have experienced a long-standing history of IPV may employ more emotion-focused coping strategies, thus placing them at a risk of developing symptoms of posttraumatic stress. This may also be true for women who have experienced high levels of violence yet employ fewer emotion-focused coping strategies. Thus, screening for a history of violence, levels of violence exposure, and use of coping strategies may inform support personnel to develop more effective and immediate responses to reduce symptoms of posttraumatic stress. According to Lilly and Graham-Bermann (2010), research has shown that a transition to more active forms of coping is perhaps necessary before recovery from the symptoms of posttraumatic stress can begin.

If we are to protect the well being of families, a "proactive" stance needs to be taken to prevent the onset and escalation of IPV. A rigorous attempt at assessing and screening all women entering all medical and mental health facilities for IPV, even those without a history of abuse, could be employed. A screening system capable of identifying signs of IPV, use of coping strategies, and current state of mental health can inform mental health and health care professionals, judicial system professionals, and community-based support staff so that they can respond in an effective and expedient manner to prevent the escalation of violence. Screening systems must be supplemented with sensitivity and compassion competency to facilitate support from all advocacy institutions and agencies from which the women seek support.

Assessing for the risk of further violence and establishing a safety plan should always be priorities at initial contact with women exposed to IPV, taking into account contextual factors of women's lives. However, once safety is ensured, screening for mental health issues and disorders and providing other suitable interventions should commence, including appropriate referrals for short and long-term follow-up from primary and mental health professionals. Faster response to early detection, crisis stabilization, and recovery could contribute greatly to the development of effective coping skills and possible resiliency for women affected by IPV. Interventions could be aimed at finding ways of supporting women to feel empowered to make the necessary changes to improve the quality of their lives and that of their children.

Efforts to understand more fully the range of coping experiences among women who have experienced IPV can, at times, be daunting given the complexities and unique circumstances that each woman faces. Hence, it is crucial to consider the women's own assessment of their resources and environment and their own evaluation of the value of coping strategies used. If a woman has "lived long enough to tell her story" of surviving the violence, she might be able to recognize that she used whatever means she had at her disposal to make it through. Surviving violence is itself a testament to a woman's ability and creativity in finding ways of coping with her situation to ensure her safety and survival. In her discussion on resilience in women who have experienced IPV, Holliman (2006) suggested that interventions that allow women opportunities to talk about their experiences encourage recovery. Through their own voices, women are empowered to further strengthen their resilience and to learn more about themselves in the process; they also learn to trust and believe in themselves.

While the results of this exploratory investigation are preliminary, they provide information suggesting the need to address the issues surrounding women's mental health and

IPV. This study found a correlation between IPV and posttraumatic stress. Further to this, the use of emotion-focused strategies as a means of coping with IPV is positively correlated with posttraumatic stress. These findings suggest that identification of posttraumatic stress is important to enhancing resilience and fostering long-term recovery from the trauma of IPV.

Many women who have experienced IPV make significant contribution to society, not the least of which is saving their children from living with violence. It is important to support the "re-empowerment" of women who have experienced IPV, assisting them to rediscover their own strength (Walker, 1980). In light of the numerous challenges they face, some researchers view women who have experienced IPV as strong, resilient, resourceful and oftentimes heroic in their efforts to cope with stress (Holliman, 2006). Thus, further research using strength-based inquiry and its impact on mental health can inform interventions to further support resiliency in women.

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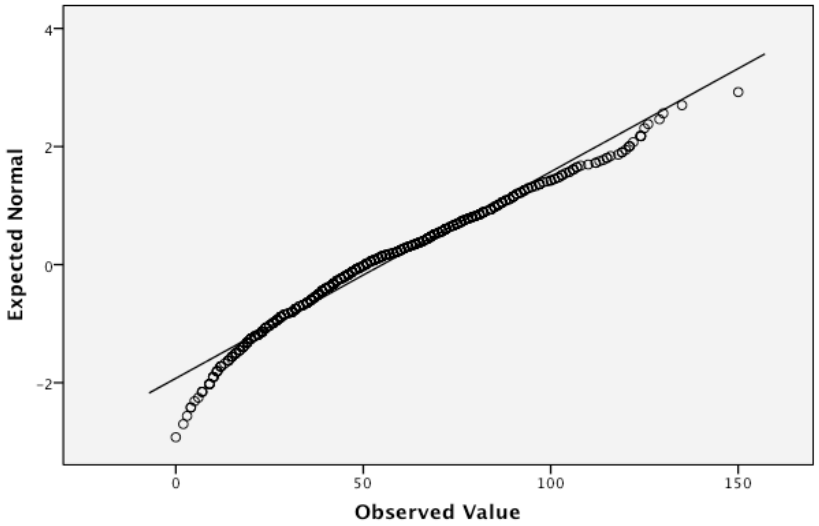
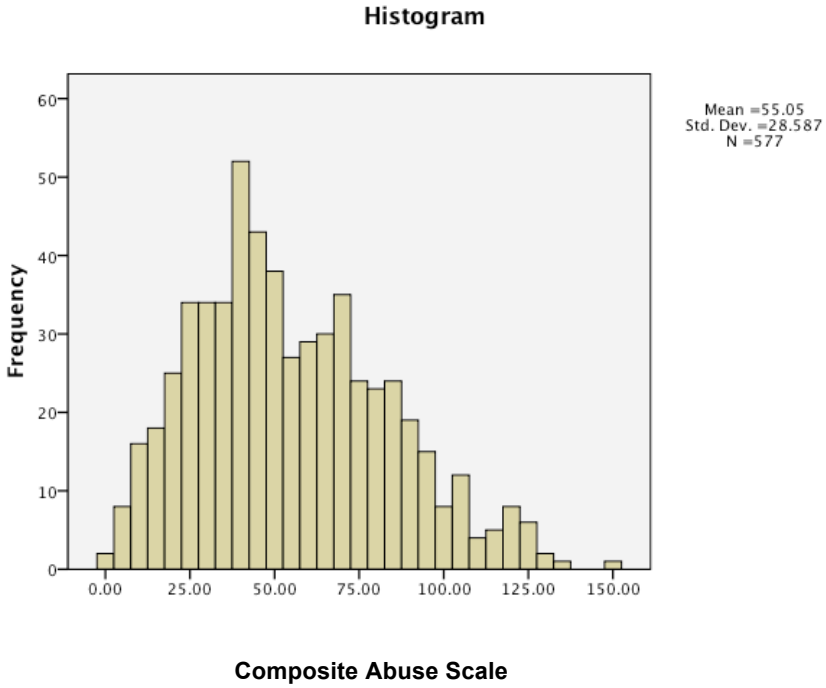
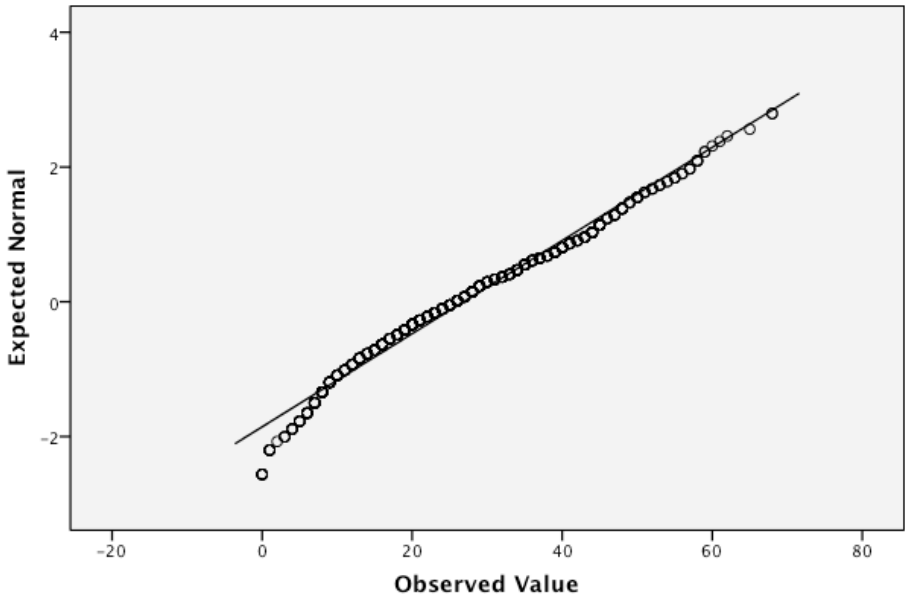
Appendix A: Normality Assumptions of the Outcome Variables (CAS, PCL and EFCS)

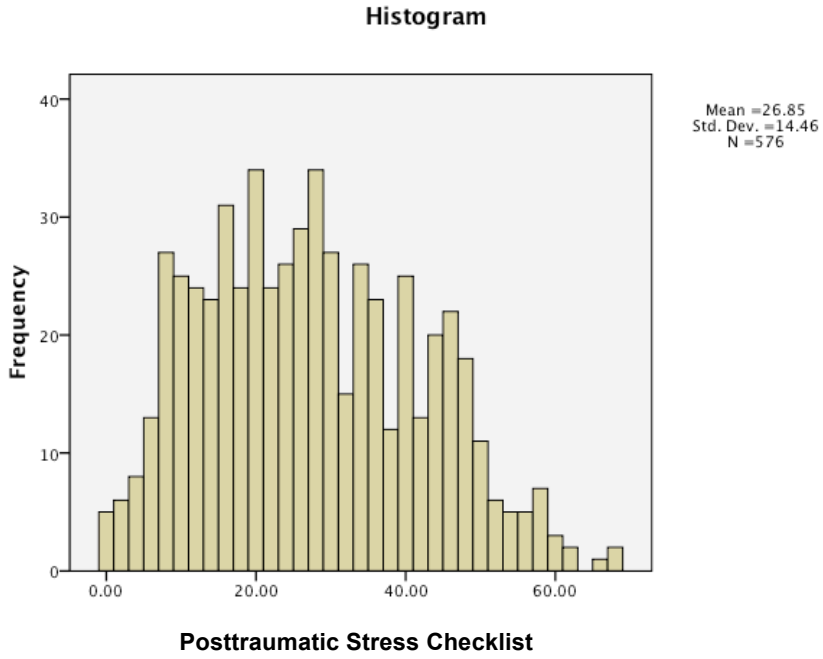
Composite Abuse Scale



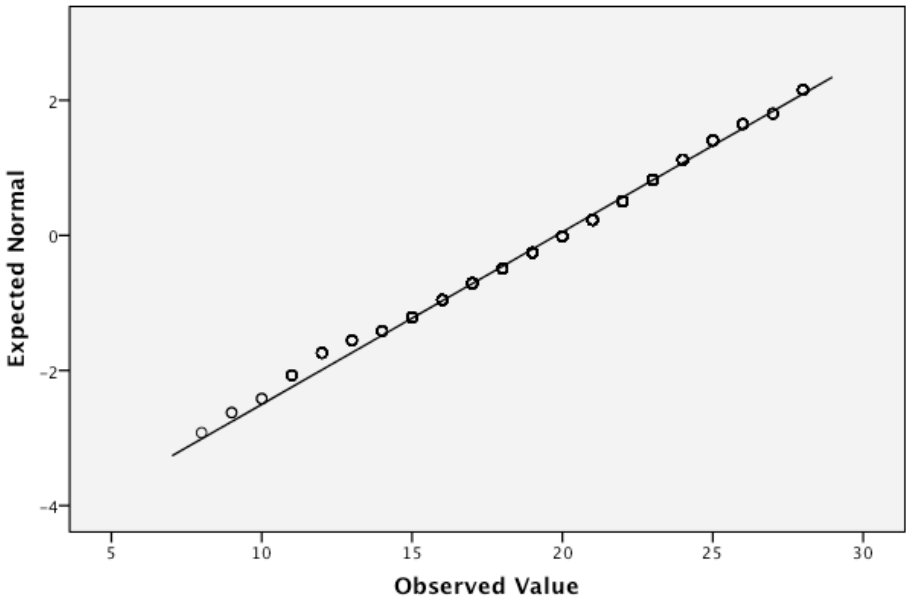


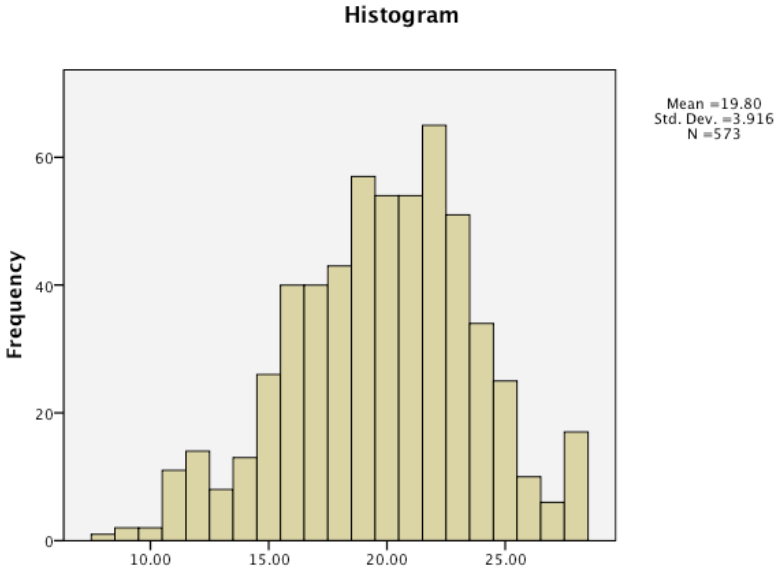
Normal Q-Q Plot of Posttraumatic Stress Checklist





Emotion-Focused Coping Strategies





Emotion-Focused Coping Strategies

All outcome variables (CAS, PCL, and EFCS) mean and median were very close to each other. Normal Q-Q plots for all variables do not show any serious departures from normality. Therefore, all outcome variables were used without transformations.

Appendix B: Questions from the Original EFCS Reference versus Questions used in the Healing Journey Project

Emotion-Focused Coping Strategy	Healing Journey Coping Scale
• Prayed for guidance and strength or meditated • Became more independent or learned to do more things for myself • Imagined myself in a better time or place • Talked to family, friends, children or other to get support • Cried to let my feelings out • Exercised more to relieve the stress and tension • Imagined myself fighting back • Tried to figure out how to leave the relationship or stay out of the relationship • Decided not to have any more sexual relationships with men • Yelled and screamed to let off steam • Made or tried to make new friends • Thought that this abuse was the result of growing up in a violent home • Became sexually involved with someone else to feel comforted • Imagined that he was dead • Thought that other are worse-off than I • Thought that he would stop being violent if he stopped using alcohol or drugs • Distracted myself from thinking about the violence and abuse • Tried to see the good parts of him • Tried to figure out why he was violent or abusive • Tried to tell myself that things weren't so bad • Used food to comfort myself • Thought that changing myself could solve • Thought about trying to kill him	• Prayed • Became more independent or learned to do more things for yourself • Imagined yourself in a better time or place • Spent time with family, friends, or kids • Cried to let your feelings out • Exercised more to relieve stress and tension • Imagined yourself fighting yourself fighting back • Tried to figure out how to leave the relationship or stay out of the relationship • Decided not to have any more sexual relationships • Yelled and screamed to let off steam • Made or tried to make new friends • Thought that your partner's abuse was the result of growing up in a violent home • Became sexually involved with someone else to feel comforted • Imagined that your partner was dead • Thought that others are worse-off than you • Thought that he would stop being violent if stopped using alcohol or drugs • Distracted myself from thinking about the violence and abuse • Tried to see the good parts of your partner • Tried to figure out why your partner was violent or abusive • Tried to tell yourself that things weren't so bad • Used food to comfort yourself • Thought that changing yourself could solve the problem • Thought about trying to kill your partner

Emotion-focused Coping Strategy	Healing Journey Coping Scale
• Told myself that my children were not being affected by his violence or abuse towards me • Tried to tell myself that I was not a "battered woman" • Thought that things would get better • Took it out on other people when I felt angry, upset, or depressed • Thought about trying to kill myself * Used alcohol or street drugs to relax or calm myself	• Thought that your children were not being affected by your partner's violence or abuse towards you • Told yourself that you were not "battered" • Thought that things would get better • Taken it out on other people when you feel angry, upset, or depressed • Thought about trying to kill yourself ** Done something creative to feel better ** Thought about the good things in your life ** Talked to a counsellor ** Focused on the future ** Listened to music, watched TV/movie or read something for pleasure ** Done nice things for yourself ** Cleaned the house ** Talked to a religious leader ** Tried to stay busy ** Spent time alone ** Tried to relax ** Thought that you could end or stay out of the relationship

* Question/variable that was not included in HJ Study
** Additional questions/variables not in EFCS

Appendix C: Coding of Demography

In the Healing Journey questionnaire each participant was asked to identify her cultural background. The following open-ended question was asked: "What is your cultural background? (For example: Aboriginal, Asian, African-Canadian, Polish, Ukrainian, etc…)"

Each response listed by participant was coded according the most appropriate variable. One response could not be coded as two (2) or more different variables. The Healing Journey Project Review Committee then determined 'the best fit'.

Category	Description
First Nations	e.g., First Nations, (Treaty) Indian, any identification with First Nation (such as Cree)
First Nations + Other	e.g., First Nations + any other identification like European, Caucasian, or Visible Minority
Métis	e.g., Métis, Half-breed
Métis + Other	e.g., Métis + any other identification like European, Caucasian, or Visible Minority
Aboriginal	e.g., Aboriginal, Native, Aboriginal + Canadian
Aboriginal + Other	e.g., Aboriginal + any other identification like European, Caucasian, or Visible Minority
Non-Status	e.g., Non-status
Inuit	e.g., Inuit
Inuit + Other	e.g., Inuit + any other identification like European, Caucasian, or Visible Minority
European	e.g., Identification with one (1) or more European countries, Portuguese, Romania, Anglo-Saxon, French-Canadian, Turkish
Caucasian	e.g., Caucasian, White, Caucasian + European
Canadian	e.g., Canadian
Visible Minority	e.g., Asian (or any countries associated with Asia), African (or any countries associated with Africa), Caribbean (or any countries

	associated with the Caribbean), Mexican, Visible Minority + European
Other Cultural/Religious Affiliation	e.g., Mennonite, Catholic, Jewish, Mixed Ancestry, American

Coded Self-Identified Cultural Background Split into either Aboriginal or Non Aboriginal Note: Inuit coded as Aboriginal (1 case).

The cultural background was coded into two categories (Aboriginal and non-Aboriginal). Aboriginals were defined as combination of First Nations, Indian, Métis, Inuit, Aboriginal, Non-status Indians, and mixture of any other identification like European, Caucasian or Visible Minority.

Non-aboriginal cultural background was defined as combination(s) of European, Caucasian, white, Asians and other."

Appendix D: Composite Abuse Scale Questionnaire

I would like to know if you experienced any of the actions/threats below and how often it happened in the last 12 months that you were with your abusive ex/partner. The following items are worded as if you were directly responding to them. Please indicate the number that matches the frequency over the 12 month period. ***(Interviewer, use Scale Package #1-DH/White Card)***

		Never	Only Once	Several Times	Once a month	Once a week	Daily
92.	Told me that I wasn't good enough.	0	1	2	3	4	5
93.	Kept me from medical care.	0	1	2	3	4	5
94.	Followed me.	0	1	2	3	4	5
95.	Tried to turn my family, friends and children against me.	0	1	2	3	4	5
96.	Locked me in the bedroom.	0	1	2	3	4	5
97.	Slapped me.	0	1	2	3	4	5
98.	Raped me. (definition: physically forced sexual act)	0	1	2	3	4	5
99.	Told me that I was ugly.	0	1	2	3	4	5
100.	Tried to keep me from seeing or talking to my family.	0	1	2	3	4	5
101.	Threw me.	0	1	2	3	4	5
102.	Hung around outside my house.	0	1	2	3	4	5
103.	Blamed me for causing their violent behaviour.	0	1	2	3	4	5

		Never	Only Once	Several Times	Once a month	Once a week	Daily
104.	Harassed me over the telephone.	0	1	2	3	4	5
105.	Shook me.	0	1	2	3	4	5
106.	Tried to rape me.	0	1	2	3	4	5
107.	Harassed me at work.	0	1	2	3	4	5
108.	Pushed, grabbed or shoved me.	0	1	2	3	4	5
109.	Used a knife or gun or other weapon.	0	1	2	3	4	5
110.	Became upset if dinner/housework wasn't done when they thought it should be.	0	1	2	3	4	5
111.	Told me I was crazy.	0	1	2	3	4	5
112.	Told me no one would ever want me.	0	1	2	3	4	5
113.	Took my wallet and left me stranded.	0	1	2	3	4	5
114.	Hit or tried to hit me with something.	0	1	2	3	4	5
115.	Did not want me to socialize with my female friends.	0	1	2	3	4	5
116.	Put foreign objects in my vagina.	0	1	2	3	4	5
117.	Refused to let me work outside the home.	0	1	2	3	4	5
118.	Kicked me, bit me or hit me with a fist.	0	1	2	3	4	5
119.	Tried to convince my family, friends, or children that I was crazy.	0	1	2	3	4	5
120.	Told me that I was stupid.	0	1	2	3	4	5

		Never	Only Once	Several Times	Once a month	Once a week	Daily
121.	Beat me up.	0	1	2	3	4	5

Appendix E
Subscales of Composite Scale

Severe Combined Abuse

93. Kept me from medical care.
96. Locked me in the bedroom.
98. Raped me. (Definition: physically forced sexual act)
106. Tried to rape me.
109. Used a knife or gun or other.
113. Took my wallet and left me stranded.
116. Put foreign object in my vagina.
117. Refused to let me work outside the home.

Emotional Abuse

92. Told me that I wasn't good enough.
95. Tried to turn my family, friends and children against me.
99. Told me that I was ugly.
100. Tried to keep me from seeing or talking to my family.
103. Blamed for causing their violent behavior.
110. Became upset if dinner/housework wasn't done when they thought it should be.
111. Told me I was crazy.
112. Told me no one would ever want me.
115. Did not want me to socialize with my female friends.
119. Tried to convince my family, friends, or children that I was crazy.
120. Told me that I was stupid.

Physical Abuse

97. Slapped me.
101. Threw me.
105. Shook me.
108. Pushed, grabbed or shoved me.
114. Hit or tried to hit me with something.
118. Kicked me, bit me or hit me with a fist.
121. Beat me up.

Harassment

94. Followed me.
102. Hung around outside my house.
104. Harassed me over the telephone.
107. Harassed me at work.

Hegarty, K., Bush, R., & Sheehan, M. (2005). The Composite Abuse Scale: Further development and assessment of reliability and validity of a multidimensional partner abuse measure in clinical settings. *Violence and Victims, 20*, 529–547.

Appendix F
Emotion-Focused Coping Strategy Questionnaire

History and Demography Update B

Below is a list of things people do to make themselves feel better after they have been abuse. Please indicate whether you have used any of the following to feel better since wave 1:

(Answer all of the yes/no questions first. Then go back to items answered "yes" and ask how helpful each was for dealing with the violence.)

(Interviewer, use Scale Package #2-DH/Blue Card)

Question: *"Have you... "*		**Circle One:** *On a scale from 0 to 4, with 0 being "not at all helpful" and 4 being "very helpful," how helpful or unhelpful was this for helping you feel better?* **Not at all helpful ←→ very helpful**
64. Spent time with family, friends, or kids?	Yes → No	0----------1----------2----------3----------4
65. Tried to see the good parts of your partner?	Yes → No	0----------1----------2----------3----------4
66. Made or tried to make new friends?	Yes → No	0----------1----------2----------3----------4
67. Tried to figure out why your partner was violent or abusive?	Yes → No	0----------1----------2----------3----------4
68. Thought that things would get better?	Yes → No	0----------1----------2----------3----------4
69. Became more independent or learned to do more things for yourself?	Yes → No	0----------1----------2----------3----------4
70. Prayed?	Yes → No	0----------1----------2----------3----------4
71. Became sexually involved with someone else to feel comforted or protected?	Yes → No	0----------1----------2----------3----------4
72. Thought that you could end or stay out of the relationship?	Yes → No	0----------1----------2----------3----------4
73. Tried to figure out how to leave or stay out of the relationship?	Yes → No	0----------1----------2----------3----------4

Question: "*Have you…*"		**not at all helpful** ⟷ **very helpful**
74. Exercised more to relieve stress and tension?	Yes → No	0----------1----------2----------3----------4
75. Imagined your partner was dead?	Yes → No	0----------1----------2----------3----------4
76. Decided not to have any more sexual relationships?	Yes → No	0----------1----------2----------3----------4
77. Imagined yourself fighting back?	Yes → No	0----------1----------2----------3----------4
78. Taken it out on other people when you feel angry, upset, or depressed?	Yes → No	0----------1----------2----------3----------4
79. Thought that changing yourself could solve the problem?	Yes → No	0----------1----------2----------3----------4
80. Distracted yourself from thinking about the violence and abuse?	Yes → No	0----------1----------2----------3----------4
81. Thought that your partner would stop being violent if he/she stopped using alcohol or drugs?	Yes → No	0----------1----------2----------3----------4
82. Thought that your partner's abuse was the result of growing up in a violent home?	Yes → No	0----------1----------2----------3----------4
83. Thought about trying to kill yourself?	Yes → No	0----------1----------2----------3----------4
84. Thought about trying to kill your partner?	Yes → No	0----------1----------2----------3----------4
85. Thought that others are worse-off than you?	Yes → No	0----------1----------2----------3----------4
86. Yelled and screamed to let off steam?	Yes → No	0----------1----------2----------3----------4
87. Cried to let your feelings out?	Yes → No	0----------1----------2----------3----------4

Question: "*Have you…*"		**not at all helpful** ⟷ **very helpful**
88. Tried to tell yourself that things weren't so bad?	Yes → No	0----------1----------2----------3----------4
89. Thought that your children were not being affected by your partner's violence or abuse towards you?	Yes → No	0----------1----------2----------3----------4
90. Told yourself that you were not "battered"?	Yes → No	0----------1----------2----------3----------4
91. Used food to comfort yourself?	Yes → No	0----------1----------2----------3----------4
92. Imagined yourself in a better time or place?	Yes → No	0----------1----------2----------3----------4
93. Done nice things for yourself?	Yes → No	0----------1----------2----------3----------4
94. Cleaned the house?	Yes → No	0----------1----------2----------3----------4
95. Spent time alone?	Yes → No	0----------1----------2----------3----------4
96. Talked to a counsellor?	Yes → No	0----------1----------2----------3----------4
97. Talked to a religious leader, like a pastor, priest, minister or elder?	Yes → No	0----------1----------2----------3----------4
98. Listened to music, watched TV or a movie, or read something for pleasure?	Yes → No	0----------1----------2----------3----------4
99. Done something creative?	Yes → No	0----------1----------2----------3----------4
100. Focused on the future?	Yes → No	0----------1----------2----------3----------4

Question: "*Have you…*"		**not at all helpful** ⟷ **very helpful**
101. Tried to rest or relax?	Yes → No	0----------1----------2----------3----------4
102. Tried to stay busy?	Yes → No	0----------1----------2----------3----------4
103. Thought about the good things in your life?	Yes → No	0----------1----------2----------3----------4

Appendix G
Posttraumatic Stress Disorder Checklist

I will read a list of problems or difficulties that people sometimes have in response to stressful life experiences, such as being assaulted or abused. Please answer using the following 5-point scale with 0 being 'Not at all' and 4 being 'Extremely'.
(Interviewer, use Scale Package #1-HP/Colour)

- Sources/Rational/Comparision
  - PCL – Compare to Dutton who used the same measure
  - References
    - Blanchard, E., Jones-Alexander, J., Buckley, T., & Forneris, C. (1996). Psychometric properties of the PTSD checklist. *Behaviour Research and Thearpy, 34*, 669-673.

0 – Not at all 1 - A little bit 2 – Moderately 3 - Quite a bit 4 - Extremely

In the past month how much have you . . . . . .

48. Been bothered by repeated, disturbing memories, thoughts, or images of abuse or violence? _____
49. Been bothered by repeated disturbing dreams about abuse? _____
50. Suddenly acted or felt as if abuse was happening again [as if you were reliving it]? _____
51. Been bothered by feeling very upset when something reminded you of abuse? _____

In the past month how much have you . . . .

52. Been bothered by having physical reactions when something reminded you of abuse, (e.g., your heart pounding, trouble breathing, sweating)? _____
53. Avoided thinking about or talking about abuse? _____
54. Avoided activities or situations because they reminded you of abuse? _____
55. Had trouble remembering important parts of abuse? _____
56. Felt a loss of interest in activities that you used to enjoy? _____

In the past month how much have you . . . .

57. Experienced feeling distant or cut off from other people? _____
58. Felt emotionally numb or unable to have loving feelings for those close to you? _____

59. Experienced feeling as if your future will somehow be cut short? _____
60. Had trouble falling asleep or staying asleep? _____
61. Experienced feeling irritable or having angry outbursts? _____

In the past month how much have you . . . .

62. Had difficulty concentrating? _____
63. Experienced being "super-alert" or watchful or on guard? _____
64. Felt jumpy or easily startled? _____

Appendix H
PTSD Subscales

Intrusion

48. Been bothered by repeated, disturbing memories, thoughts, or images of abuse or violence?
49. Been bothered by repeated disturbing dreams about abuse?
50. Suddenly acted or felt as if abuse was happening [as if you were reliving it]?
51. Been bothered by feeling very upset when something reminded you of abuse

Avoidance

52. Been bothered by having physical reactions when something reminded you of abuse?
53. Avoided activities or situations because they reminded you of abuse?
54. Avoided activities of or situations because they reminded you of abuse?
55. Had trouble remembering important parts of abuse?
56. Felt a loss of interest in activities that you used to enjoy?

Numbing

57. Experienced feeling distant or cut off from other people?
58. Felt emotionally numb or unable to have loving feelings for those close to you?
59. Experienced feeling as if your future will somehow be cut short?
60. Had trouble falling asleep or staying asleep?
61. Experienced feeling irritable or having angry outbursts?

Arousal

62. Had difficulty concentrating?
63. Experienced being "super-alert" or watchful or on guard?
64. Felt jumpy or easily startled?

Blanchard, E.B., Jones-Alexander, J., Buckley, T.C., & Forneris, C.A. (1996). Psychometric properties of the PTSD Checklist (PCL). *Behavior Research and Therapy, 34*, 669–673.